Rockingham County Division of Public Health
2024-2025 Policy Table of Contents

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

ADMINISTRATIVE POLICIES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TIME STUDY

DATE DEVELOPED: 10/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/22

I. POLICY:

The Division of Public Health Services' staff members shall maintain daily employee time records to document employee salaries and fringe benefits charged to state funds. The percentage of time each employee spends in each activity shall be converted to dollars based upon the employee's salary and benefits.

II. PURPOSE:

A. To provide guidance in recording time in iiTimeSheets.

- iiTimeSheets is the software system used to record the documentation of actual work activity by program and to record daily time in/out of work.

B. The Division of Public Health Services' staff members will use iiTimeSheets to maintain a daily time record. The time record is kept in order to document employee salaries and fringe benefits charged to state funds and to determine the costs of providing Medicaid services. The iiTimeSheet is due on the last working day of the pay period by 9:00 a.m. Supervisors are responsible for verifying the accuracy of the iiTimeSheet, and certifying promptly for processing.

C. The Time Study is a requirement of the State Consolidated Agreement. It is used to determine labor cost of providing services. Staff members are required to record time worked to the applicable program. When time for all staff members is collected and recorded it is converted to percentages of time worked in each program. Salary and fringe benefits are applied for each staff member using this percentage to the applicable program. This process assists departments in knowing a cost basis to apply to applicable grants or other additional funds that may be available. It also enables management to recoup the cost of providing services from payer sources.

D. Medicaid Cost Report

Effective July 1, 2012, Nurses, Social Workers, and Outreach Workers (Health Educators and Nutritionists) are required to complete an Actual

Time Study, which is generated by iiTimeSheets, that will document the direct clinical service activity as well as the non-clinical and laboratory service activity. Also Care Management for At Risk Children (CMARC), Care Management for High Risk Pregnancies (CMHRP), general administration, and paid time off will be recorded. This information is required for the Medicaid Cost Report.

The iiTimeSheet must show the actual time spent within each program area.

III. PROCEDURE:

iiTimesheets

1. RCDPH utilizes iiTimeSheets software for the documentation of actual work activity by program and is used to determine the labor costs of providing services.
2. The iiTimeSheets software will reflect all programs.
3. Individual employee time equivalency records are set up by pay period.
4. iiTimeSheets is web based and can be accessed where there is internet connectivity.
5. Each employee will maintain a time equivalency record in iiTimeSheets to document his/her actual daily work activity. Documentation should be made on a daily basis to assure accuracy.
6. After his/her last time entry for the current pay period, the employee will certify his/her time entries for that pay period.
    a. This certification serves as the employee's signature on the time record indicating that the time entered for the pay period is accurate according to the daily activity performed.
    b. The total hours reported by each employee must balance to the total hours worked and paid for as reported to the county in OneSolution (electronic payroll system).
    c. In the event an employee is out of the office and unable to complete and certify his/her time sheet, the employee's supervisor/designee or timekeeper may do so on the employee's behalf.
7. Each employee's certified time equivalency record must be reviewed by his/her supervisor. Supervisors will designate a back-up supervisor(s) to review on their behalf in the event they are unable to complete the review themselves. The listing of back-up supervisors will be maintained by the Health Department's time-keeping staff and can be found in the Admin Menu of iiTimeSheets.

a. Supervisors will alert employees of any time record discrepancies that may exist.
b. Employee will make necessary corrections on his/her time equivalency record and will re-certify to indicate that the time equivalency record is accurate.

8. After review of employees' time equivalency records is complete, the supervisor (or designated back-up) will approve the iiTimeSheets. The supervisor's approval of the iiTimSheet will serve as the supervisor's signature on the time equivalency record indicating that the time entered for the pay period is accurate.

9. After completion of supervisor's approvals of iiTimeSheets, Health Department time-keeping staff will review employees' iiTimeSheets to ensure that the time entered corresponds with the actual time worked as reported in OneSolution.

   a. Time-keeping staff will alert employees and their supervisor of any discrepancies that may exist.
   b. Employee will make necessary correction(s) on his/her iiTimeSheet and will re-certify to indicate that the time equivalency record is accurate.
   c. Upon completion of re-certification of iiTimeSheet by employee, the supervisor will re-approve. The supervisor's re-approval of the time sheet will serve as his/her signature that the employee's time equivalency record is accurate.

10. Time-keeping staff will lock a pay period after all certifications and approvals are complete. Locking of a pay period will allow the Health Department Finance staff to generate a Summary Report that will indicate how time should be allocated in the WIRM report.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TARDINESS

DATE DEVELOPED: 6/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18

I. POLICY:

The Division of Public Health Services expects each employee to be accountable for time during working hours.

II. PURPOSE:

To assure the Health Department staff meets the needs of our clients during normal business hours.

III. GUIDELINES:

A. All employees are expected to be at their workstations ready for work by 8:00 a.m., unless their pre-approved work schedule differs from the normal 8-5 schedule.

B. Supervisors are responsible for documentation of tardiness.

C. Each employee is required to make up any time owed to the county due to tardiness.

D. Any employee realizing they will be tardy is expected to contact their supervisor for notification, prior to work time assigned if possible. This will allow the supervisor to make the necessary arrangements.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMPLOYEE VACATION AND SICK LEAVE

DATE DEVELOPED: 1/83
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 10/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/18; 10/22

I. POLICY:

The Division of Public Health Services allowance for vacation and sick leave.

II. PURPOSE:

To establish a system to document earned time taken by employees of the Health Department.

III. GUIDELINES:

A. All employees are expected to be at their workstation at 8:00 am and to work at assignment until 5:00 pm excluding lunchtime. Any digression from this policy must be approved by the supervisor.

Flex schedule may be approved by the Health Director and/or Director of Nursing/Supervisors and may be approved only if it does not interfere with the normal operation of the area to which the employee is assigned.

All employees who earn vacation and/or sick leave will be allowed to take vacation/sick time off in ½ hour (.50) increments.

B. Employees with accumulated vacation time will not be granted leave without pay for vacation purposes until all leave has been exhausted. Leave without pay will only be granted in cases of emergency, with specific approval by the Health Director.

C. Employees with accumulated vacation or sick time will not be granted leave without pay for personal, or family illness until all leave has been exhausted.

D. For purposes of this policy, all absences from work shall be considered vacation absences except for actual personal or family death or illness. Approved leave shall be administered in compliance with the Rockingham County Personnel Policy.

E. This policy shall be in effect for employees absent from work under the Family Medical Leave Act and Community Leave.

F. This policy will not apply to military leave, service leave, bereavement leave, civil leave, or parental leave as defined in the Rockingham County Employee Handbook.

G. Employees serving a probationary period following appointment may accumulate vacation leave and shall be permitted to take vacation leave during the probationary period, with the prior approval of the appointing authority.

H. Temporary employees do not receive vacation leave.

I. Full-time, post-probationary, and probationary employees working the basic workweek of 40 hours shall earn sick leave. Sick and vacation leave for employees working 20 or more hours per week shall be pro-rated according to the Rockingham County Personnel Policy.

J. Temporary employees do not receive sick leave with pay.

K. A completed Leave Record must be submitted to the supervisor in writing prior to leave absence. It is imperative that the payroll clerk have this information for your check to be accurate.

VACATION LEAVE:

L. Vacation leave will be approved at the convenience of the department and on a first come first served basis, and with supervisor's prior approval. Requests for 5 or more days must be reviewed and approved by the Health Director.

M. Vacation leave should be requested as early as possible to better assure the employee will be granted those days requested.

N. Vacation leave requested on short notice may not be granted if it will interfere in the normal daily operation of the Health Department.

O. All leave slips should match recorded leave on iTimeSheets report.

SICK LEAVE:

P. If an employee is unable to report to work in the a.m. the program supervisor must be notified no later than 7:00 a.m. of that day. This allows for assignments to be rearranged. If the employee has scheduled appointments or special assignments he/she will make all necessary arrangements to cancel, reschedule or facilitate another employees' carrying out the assignment.

Q. If for any reason the employee, during the course of the day, is able to return to work he/she should do so by letting the supervisor know. No employee is expected to work ill, especially when illness is contagious.

R. Sick leave slips should be submitted to the supervisor on the first day back to work from an unscheduled sick leave.

S. If employee becomes ill during work hours, a leave slip should be submitted to supervisor prior to leaving the building if possible.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMPLOYEE TRAVEL REIMBURSEMENTS

DATE DEVELOPED: 7/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/18

I. POLICY:

The Division of Public Health Services will reimburse employees for approved travel expenses incurred during the performance of their jobs.

II. PURPOSE:

To document approved travel expenses incurred by employees on a monthly basis.

III. GUIDELINES:

A. All public health travel reports must be completed and signed by the employee incurring the expense. (*See County travel forms attached*).

B. Travel reports must be approved and signed by section supervisors.

C. The Health Director must approve travel reports requiring reimbursement to section supervisors.

D. Travel reimbursements are processed one time monthly and are to be turned in to the Accounting Assistant by the close of business on the 2nd working day following the reporting month.

E. Travel approval and reimbursements will be made in accordance with the Rockingham County Travel Policy.

F. Required documentation for accommodations does not include credit card receipts or copies of cancelled checks. Only bills from hotels, restaurants, etc., will be accepted for reimbursement.

G. Employees may not be provided a per diem for any meal that is included as an integral part of a conference and included in the conference fee or paid by a third party.

H. Include name and location of conference or meeting on the travel report, and the date attended.

I. A completed registration form must accompany an approved requisition if pre-payment is requested.

J. All pre-registrations are the responsibility of the employee attending conferences, workshops, etc.

K. Receipts for reimbursement must be attached to the travel report.

L. All travel reports not properly completed will be returned to the section supervisor, and may delay reimbursement to the employee.

M. Overnight accommodations for two or more employees.

1. Due to limited funding in the department's staff training line item accounts, employees are encouraged to share hotel rooms to defray costs to the County for separate rooms for overnight stays while attending the same conference.
2. Special consideration may be approved prior to making reservations. Employees are encouraged to discuss with immediate supervisor prior to making hotel reservations.
3. Employees that choose to reserve separate hotel rooms without prior approval will be responsible for the cost of the room.

Rev/di

Rockingham County

Pre-Authorization Travel Form / Pre-Authorization for Out of State Travel

Employee Name: _____ **Department Name:** _____

Date of Request: _____ **Amount of Advance:** _____

Use this form to request authorization for any day travel or travel away from home. All day travel and travel away from home must have pre-authorization before incurring any expenses related to that travel. Examples of these costs include: registration fees, hotel costs, and flight costs. The following information must be attached to the authorization form: course/conference info; hotel estimates; and any other costs. Please include the training information under purpose of travel and the dates to attend. A copy of the approved/signed form must be submitted with the procurement card bill for any travel/training costs and to request reimbursement for personal costs associated with the trip. Failure to submit proper paperwork and documentation can result in deduction of the travel costs from the employee's paycheck and refusal to issue future travel authorizations. Also use this form to request pre-authorization for all out of state travel. Travel outside the boundaries of the state of North Carolina requires County Manager approval prior to travel.

_____

Employee Signature

Purpose of Travel

Transportation ***

County Vehicle or County Pool Vehicle Available? (Y/N)

Justification required if personal vehicle/mileage reimbursement being requested:

Date	Depart Time	Return Time	Breakfast	Lunch	Dinner	Incidentals $5	Other Expense (receipt required)	Total Day Expense
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00

**Registration Fees, Hotel Charges, Mileage Costs, and Flight Charges should be listed in Other Expense Column

**For Breakfast - must depart prior to 7:00 a.m.

**For Lunch - must depart prior to 10:00 a.m. & return after 2:00 p.m.

**For Dinner - must return after 6:30 p.m.

**Any meal provided at your conference / meeting cannot be claimed for reimbursement.

**Any meal paid for by county procurement card should NOT be included on this form.

**Incidentals reimbursement is one claim for each overnight hotel stay.

***Mileage reimbursement allowed only if a county vehicle is not available, use of County vehicle is not practical, a specialty vehicle is required, or the employee is not allowed to operate a County vehicle. Employee must verify that a departmental vehicle nor a county pool vehicle is available for use or provide other qualifying justification.

Grand Total of all expenses above: **$0.00**

Approved by: _____ **Date Approved:** _____

Department Head Approval: _____ **Date Approved:** _____

County Manager Approval: _____ **Date Approved:** _____

(For Out of state)

Finance Dept. Approval: _____ **Date Approved:** _____

Rockingham County, North Carolina

Conference & Trip Report

Conference Title	
Dates Attended	
Location	
Purpose	

About the Conference

Sessions Attended

Key Lessons and Action Items

Key Relationships

Rockingham County Taxable Employee Fringe Benefit

Day Travel Meals Expense Form

(Processed through payroll on the last payroll of the month only)

Employee Name: _____ **Department Name:** _____

Date of Request: _____ **Amount of Request:** _____

This form is only to be used for meal expenses. Do NOT include meals that have been charged to the county procurement card when filling out this form. The county will reimburse for meals in accordance with rates published by the General Services Administration (GSA). These rates are currently available at http://www.gsa.gov/portal/content/101518. The reimbursement rate is based on the location of the work/conference/meeting activity. If the City or County where the travel occurred is not specifically listed on the website, then the standard rate will be used. The standard rate for NC for calendar year 2023 is $13 Breakfast, $15 Lunch, and $26 Dinner. IRS regulations state that meals claimed for non-overnight trips are to be reported as taxable income. Therefore, meal reimbursement for same day travel will be reimbursed to employee via the payroll system and will be reported as taxable wages.

I certify this is a true and accurate statement of expenses incurred in the conduct of official Rockingham County Business and also acknowledge this is a taxable employee fringe benefit and will be reported on my W-2 as taxable wages.

_____

Employee Signature

Destination	Purpose of Travel	Date	Depart Time	Return Time	Breakfast	Lunch	Dinner	Total Day Expense
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00

**For Destination include City/County/State
**For Breakfast - must depart prior to 7:00 a.m.
**For Lunch - must depart prior to 10:00 a.m. & return after 2:00 p.m.
**For Dinner - must return after 6:30 p.m.
**Any meal provided at your conference / meeting cannot be claimed for reimbursement.
**Any meal paid for by county procurement card should NOT be included on this form.

Grand Total of all expenses above: **$0.00** **Account to Charge:** _____

Approved by: _____ **Date Approved:** _____

Department Head Approval: _____ **Date Approved:** _____

Finance Dept. Approval: _____ **Date Approved:** _____

ROCKINGHAM COUNTY
TRAVEL AWAY FROM HOME REIMBURSEMENT

NAME:		DATE OF REQUEST:		AMOUNT
DEPARTMENT:		ACCOUNT CODE:		
DESTINATION / PURPOSE OF TRAVEL: CITY/COUNTY/STATE		ACCOUNT CODE:		
		ACCOUNT CODE:		

DATE OF EXPENSE:								TOTALS
DEPARTURE TIME								
RETURN TIME								
INCIDENTALS ($5)								$0.00
BREAKFAST								$0.00
LUNCH								$0.00
DINNER								$0.00
Gas County Car Number _____								$0.00
OTHER (ATTACH RECEIPT OR EXPLANATION)								$0.00
PERSONAL CAR MILEAGE FROM MILEAGE LOG (Mileage Log Required)								
LODGING PAID BY PROCUREMENT OR ACCOUNTS PAYABLE								$0.00
MEALS PAID BY PROCUREMENT								$0.00
REGISTRATION, AIRFARE OR CHECKED BAGGAGE PAID BY PROCUREMENT OR AP								$0.00
TOTALS	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	

*Attach Mileage Log if Used.

PLEASE ATTACH RECEIPTS & DOCUMENTATION AS REQUIRED

GRAND TOTAL EXPENSES	
PRE-PAID EXPENSES	$0.00
ADVANCES	
TOTAL DUE TO COUNTY EMPLOYEE	**$0.00**

I certify that this is a true accurate statement of expenses incurred in the conduct of official Rockingham County business.

_____
EMPLOYEE SIGNATURE

_____
APPROVED BY

_____
DEPARTMENT HEAD APPROVAL
(If required)

_____
FINANCE DEPARTMENT APPROVAL

**This form is NOT to be used for Day Travel Meals Expenses

**All expenses included on procurement card or through accounts payable must be recorded.

The county will pay per diem meals, gratuities, and overnight incidental expenses in accordance with rates published by the General Services Administration (GSA) for destinations within the Continental US (CONUS). http://www.gsa.gov/portal/content/101518. The reimbursement rate is based on the **location of the work/conference/meeting activity. If the City or County where the travel occurred is not specifically listed on the website, then the standard rate will be used. The standard rate for NC for calendar year 2023 is $13 Breakfast, $15 Lunch, and $26 Dinner.

**Incidentals are fees and tips given to porters, baggage carriers, bellhops and hotel staff and claimed based on number of overnight hotel stays.

**Any meal that is inclusive with your travel purpose and paid for or provided by a third party cannot be claimed for reimbursement.

**The First and Last Day of travel will be reimbursed based on departure time on the first day of travel and return time on the last day of travel. Conference/Training/Meeting location and agenda will be used to determine reasonable departure and return times.

COMMENTS OR NOTES:

ROCKINGHAM COUNTY
MILEAGE LOG

NAME:		DEPARTMENT	

DATE	Travel		Purpose	Reason County Vehicle Not Used*	# of MILES
	From	To			
				TOTAL MILES	
				Times Mileage Rate in Dollars	$0.655
				Reimbursement Form	

* Per Travel Policy 4.06: Mileage reimbursement for use of personal vehicle is allowed only if no County vehicle is available, use of County vehicle is not practical, a specially equipped vehicle is required, or the employee is not allowed to operate a County vehicle.

Employee must verify that a departmental vehicle nor a county pool vehicle was available for use or provide other justification.

ROCKINGHAM COUNTY
PERSONAL VEHICLE MILEAGE
MILEAGE ONLY

NAME:		DEPARTMENT:	

DATE	Travel		Purpose	Reason County Vehicle Not Used *	# of MILES
	From	To			
				TOTAL MILES	
				Times Mileage Rate in Dollars	$0.655

Account Number to Charge	Amount

The Personal Mileage Form should be used if you are requesting mileage reimbursement only. Use the Travel Reimbursement Form for reimbursement that includes mileage and other travel expenditures.

I certify that this is a true and accurate statement of expense incurred in the conduct of official Rockingham County Business

* Per Travel Policy 4.06: Mileage reimbursement for use of personal vehicle is allowed only if no County vehicle is available, use of County vehicle is not practical, a specially equipped vehicle is required, or the employee is not allowed to operate a County vehicle.

Employee must verify that a departmental vehicle nor a county pool vehicle was available for use or provide other justification.

EMPLOYEE SIGNATURE

APPROVED BY

DEPARTMENT HEAD APPROVAL
if required

FINANCE DEPARTMENT APPROVAL

Rockingham County
Travel Advance Request Form

Employee Name: _____ **Department Name:** _____

Date of Request: _____ **Amount of Advance:** _____

Use this form to request an advance for Travel Expenses that are **NOT** to be paid for by the county procurement card or paid in advance by accounts payable. Travel advances are loans for which employees assume full responsibility for repayment through complete & timely submission of all receipts after their return. Failure to submit proper paperwork and documentation can result in deduction of the travel advance from the employee's paycheck and refusal to issue future travel advances.

_____
Employee Signature

Purpose of Travel

Transportation **
County Vehicle or County Pool Vehicle Available? (Y/N)
Justification required if personal vehicle/mileage reimbursement being requested:

Date	Depart Time	Return Time	Breakfast	Lunch	Dinner	Incidentals $5	Other Expense (receipt required)	Total Day Expense
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00

**** Per Travel Policy 4.06: Mileage reimbursement for use of personal vehicle is allowed only if no County vehicle is available, use of County vehicle is not practical, a specially equipped vehicle is required, or the employee is not allowed to operate a County vehicle. Employee must verify that a departmental vehicle nor a county pool vehicle was available for use or provide other justification.**

Grand Total of all expenses above: **$0.00** **Account to Charge:** _____

Approved by: _____ **Date Approved:** _____

Department Head Approval: _____ **Date Approved:** _____

Finance Dept. Approval: _____ **Date Approved:** _____

Rockingham County

Request for Payment Form

Finance Use Only	
Vendor #	
Date	

Date of Request

Total Check Amount Requested $ -

Department From: Finance

PAY TO:
REMITTANCE ADDRESS

Reason for Payment:
(Reason only needed if no Invoice attached)

Line	Fund	Department	Activity	Object	Description	Amount
1						-
2						-
3						-
4						-
5						-
6						-
7						-
8						-
9						-
10						-

Special Instructions:

_____ Process the Attached item('s) and mail check to payee.

_____ Enclose attached documents with check

_____ Return check to department for Disposition. Reason:

_____ Notify Department when ready for Pickup. Reason:

Approved for Payment

Department Official

Approved for Payment

Finance Department

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TELEPHONE USAGE

DATE DEVELOPED: 9/1/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18

I. POLICY:

The Division of Public Health Services provides cellular phones to field staff, directors, supervisors, and Public Health Preparedness staff. Staff may also use personal cell phones for work purposes. Most staff members are provided a desk phone with individual phone numbers.

II. PURPOSE:

The phones are provided to health department staff to facilitate program services, as a safety factor, and to be used only for health department services.

III. GUIDELINES:

Telephones:

A. Telephones (desk/cellular) are to be used for business purposes only if provided by the county.

B. Personal telephone calls should be limited during business hours. Please see that your family has other staff members phone numbers so if there is an emergency and you cannot be reached on your phone they have other options.

C. Employees should not use personal cellular phones during business hours with the exception of breaks or lunch times. County assigned cellular phones are not to be used for incoming or outgoing personal calls except for emergencies.

D. Inappropriate use of county assigned cellular telephones that result in charges to the county must be reimbursed to the county by the employee. It is the employee's responsibility to ensure proper reimbursement to the county. Mobile phone charges/calls are routinely monitored.

E. A county assigned cellular phone should be in the "on" mode in order for the agency to reach you in case of emergency or change in assignment.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MAIL PROCEDURES

DATE DEVELOPED: 7/95
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/19; 6/24

I. POLICY:

All mail delivered to the Division of Public Health Services will be distributed from the Administrative Section.

II. PURPOSE:

To establish a structured process for retrieval and distribution of the incoming and outgoing mail of the Health Department.

III. GUIDELINES:

A. INCOMING MAIL

1. Courier – 8:00 a.m.

   a. Pick-up Health department and other governmental county agency mail (except DSS) from Courier Box. (Need Key).
   b. Open lab envelope and date each **page**. Separate water sample reports and give to appropriate Environmental Health personnel. All clinical lab reports are to be returned to original envelope.
   c. Take lab envelope down to laboratory and **place it on the ledge located on the** lab door. Water samples are placed in the OSWW Program Coordinator's mail box in EH.
   d. All other courier mail is to be opened, dated, sorted and combined with the US mail to be distributed to designated sections of the agency.
   e. Give WIC mail, including any mail marked attention of WIC Director, to WIC **Administrative Assistant I.**

2. Distribute Regular Mail – 8:30 a.m.

   a. Open all mail, date, sort, and distribute as follows:
      (1) All Communicable Disease Report Cards go to the Communicable Disease Nurse.
      (2) Do not open anything marked Child Fatality**,** stamp and give to Health Director's Administrative Assistant.

(3) Do not open any envelopes going to Vital Statistics (i.e. funeral homes, medical examiners, or envelopes marked deputy registrar). Give to Deputy Registrar, Stamp Envelopes Only. Do not stamp document.

(4) Give all requests for clinical records to the Administrative Assistant III position.

(5) CMARC and CMHRP letters go to PCM Coordinator along with any bills from cab companies.

(6) All other bills go to the Accounting Assistant.

(7) All checks, money, and money orders must be logged into the **Funds Received Log**. All clinical payments go to the Billing Coordinator, and all Environmental Health checks/payments go to Central Permitting. All other checks go to the Accounting Assistant.

(8) Distribute mail to mailboxes in the 2nd floor mailroom for Health Department personnel who have offices on the 2nd floor. Distribute clinic staff mail to mailboxes in the clinic mailroom located on the 1st floor for the clinical staff. All other mail for the Office Administration personnel for the clinic section is to be given to the Administrative Assistant III for distribution. The **Personnel Technician** position will distribute in her absence. Take lab envelope down to the Administrative Assistant III position. If she is not here give to the Administrative Assistant I position.

(9) All mail for the Environmental Health Section is to be given to each individual it is addressed to. All checks are given to Central Permitting.

(10) Mail going to other County agencies to be placed in mailboxes located in copy room next to the Finance department.

(11) All boxes/packages received in U.S. Mail are to be opened and given to the Accounting Assistant for verification.

(12) All faxes **received via email** are forwarded to the designated staff member or to **Triage**.

B. OUT-GOING MAIL:

1. Regular Mail – 12:00 p.m.

a. Collect mail from downstairs at 12:00 p.m. daily. Bring upstairs to Copy Room.

b. Batch downstairs mail with upstairs mail according to postage account numbers.

c. Take to designated location next to Finance department and place in mail bin marked OUTGOING MAIL AND/OR STAMPED AND POSTAGE PAID to be picked up by Central Services Personnel.

2. Courier Mail – 4:50 p.m.

a. Collect faxes from 2nd floor fax tray in copy room to distribute as appropriate.
b. Collect, bag, and attach bar code to courier mail.
c. Collect courier mail from 1st floor and batch with 2nd floor mail.
d. Lab Work and Regular Mail to be bagged separately.
e. All boxes are mailed separately with bar code attached to each – do not bag.
f. Each item mailed individually must have a bar code on it (i.e. boxes, packages over 1 lb). These do not have to be bagged.
g. All envelopes must be bagged together. Place bar code sheet in bag. Bar code should be visible from outside of bag.
h. Bar code sheets and bags are in drawer of mail desk.
i. Bar codes are copied from last bar code sheet and stored in desk drawer located in copy room. Bags are ordered from Laboratory Supply Company by the Accounting Assistant upon request.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CONSENT TO PHOTOGRAPH

DATE DEVELOPD: 4/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services may need to photograph clients seen for services.

II. PURPOSE:

To establish guidelines necessary to ensure compliance in photographing clients.

III. GUIDELINES:

A. It is not customary or routine that the health department staff photograph clients that present for services.

B. The following list identifies when a photograph may be taken during hours of operation:

1. Indication of medical condition or healing process

2. Assisting in the communication or collaboration of the client's medical condition to another health care provider and/or third party payor.

3. For educational presentations and/or publicity describing services of the Division of Public Health Services.

C. The consent form and explanation for the photograph will be reviewed and signed by the client prior to the photograph being taken.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

CONSENT FOR CLIENT PHOTOGRAPH AND STATEMENT

I, _____, give my consent for Rockingham County
(Client/Guardian/Power of Attorney)

Division of Public Health to photograph _____
(Client/Anatomical area to be photographed)

and share the information I provided in the area written below. I consent for the photograph and information to be used for: (initial selection)

_____ A. Indicating my medical condition and/or healing process as applicable to other health care providers and/or third party payors.

_____ B. Educational presentations and/or publicity describing Rockingham County Division of Public Health services.

Comments:

_____
_____
_____
_____
_____
_____
_____
_____

_____
(Client/Guardian/Power of Attorney)

_____
(Witness)

_____
(Date)

Revised 11/30/15

DEPARTAMENTO DE SALUD Y SERVICIOS HUMANOS DEL CONDADO DE ROCKINGHAM

Consentimiento Para Fotografía y Declaración Del Cliente

Yo, _____, doy mi consentimiento para que la División de
(cliente/guardián/poder legal)

Salud Pública del Condado de Rockingham fotografíe a _____
(cliente/area anatómica para ser fotografiada)

y compartir la información que proporcioné en el área escrita a continuación. Doy mi consentimiento para que se utilice la fotografía y la información: (ponga iniciales en seleción)

_____ A. Indicando mi condición médica y/o proceso de curación según corresponda a otro proveedor de atención médica y/o tercer pagadores.

_____ B. Presentaciones educativas y/o publicidad que describen los servicios de la División de Salud Pública del Condado de Rockingham.

Comentarios:

_____

_____

_____

_____

_____

_____
(cliente/guardián/poder legal)

_____
(testigo)

_____
(fecha)

Revised 11/14/18 (cg/mb)

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: REDUCTION-IN-FORCE

DATE DEVELOPED: 8/11/1981
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services has identified procedures to follow in the event of a need in Reduction-In-Force for post-probationary employees.

II. PURPOSE:

It is the intent of the Division of Public Health Services to treat all employees fairly in the application of rules and policies dealing with work force reductions for reasons of curtailment of work or lack of funds.

III. GUIDELINES:

A. Such reductions shall be made without regard to race, color, creed, religion, sex, national origin, political affiliation, age, physical handicap, or any other factor that does not fully recognize the employee's privacy and constitutional rights as citizens.

B. Retention or dismissal of employees due to work curtailment or lack of funds shall be done in a systematic manner based upon criteria that ensures the maintenance of all current services to the fullest extent possible, maintains accountability, and ensures that program quality shall not be diminished.

C. Recognizing that the Department already operates with limited resources and that further cutbacks appear imminent, such simplistic approaches as "last in – first out" or "if the program goes, the people working in it go", will do tremendous harm to the objectives of the agency.

D. In order to continue in the spirit of using tax dollars wisely, flexibility must be granted to administration to retain the Department's most productive resources there by maintaining priority and mandated services. To achieve the philosophy herein expressed, the following policies shall guide the Department in any work force reductions due to lack of funds.

The policies used shall be applied in the order listed with any action taken having the approval of the Department Director:

1. Critical nature of duties/skills

2. Productivity of Employee (Job Performance)

3. Length of Service

4. Specific program reductions of funds

The above criteria shall be applied as follows:

1. Critical Nature of Duties/Skills

   The Director, in conjunction with appropriate supervisory personnel of the Department, shall determine agency priorities of programs as well as activities within programs. Such priority listing shall remain confidential information except for administrative purposes, and shall be applied only for personnel or program reductions. A Critical Duty or Skill may be a position that could have its duties absorbed by one, two, or three other persons, and would not severely detract from program objectives. An example might be an outreach worker whose duties could be assumed in part by a nurse, and a clerk, using either the telephone or mail to contact clients. Admittedly, a degree of effectiveness would be lost but the majority clinical aspects of the service would remain intact.

2. Productivity of Employee

   All employees do not produce equal results for equal time. Part of this is due to a lack of motivation or desire on the part of the employee to achieve. In times of dwindling resources, it is mandatory that the most possible output be received from decreasing input. Therefore, if two or more employees are fairly evenly matched in terms of No. 1 above (Critical Duties/Skills), program supervisors shall determine productivity of the affected persons. This determination from a review of previous evaluations and daily or weekly reports of the employee's activities. Personal, signed statements by program coordinators may be used if it is determined that personality conflicts are not involved.

3. Length of Service

   If two or more persons to be potentially affected by reductions in force remain equivalent after application of numbers (1) and (2) above, the personnel records shall be reviewed to determine which employee has greater time within that particular job function. The

employee with more satisfactory employment time shall be given the opportunity to be retained over the employee with lesser time.

4. Specific Program Reductions of Funds

If two or more employees should remain equal after application of (1), (2), and (3) above, the employee working in the specific program having its funds reduced shall be dismissed. Employees are informed of the source of their program support at the time of employment. They would, therefore, be aware that reductions in that program area could adversely affect their employment. Such employees would have the option of transferring to other program areas if funded vacancies in their job class existed either from resignations or reduction in force dismissals carried out in accordance with these policies.

E. General Provisions

The Health Director is hereby directed to apply these policies only as necessary to meet shrinking funding levels, to notify each affected employee as far in advance as possible of pending dismissal, to inform each employee in writing, and to assist affected employees who may be seeking other employment by providing references etc., if requested.

The Health Director is also instructed to review current budgets carefully and seek other ways of reducing the budget, if possible, without reducing personnel.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMPLOYEE VACCINATION REQUIREMENTS

DATE DEVELOPED: 12/05
REVIEWED: 6/17; 6/18; 6/19; 12/19; 6/20; 6/21; 6/22; 3/23; 6/23; 6/24
REVISED: 9/14; 11/15; 6/19; 12/19; 3/23

I. POLICY:

The Division of Public Health Services will track employee immunization status.

II. PURPOSE:

To provide a safe working environment and to assist the employee in maintaining optimum health in order to safeguard the health and well being of clients and staff.

III. GUIDELINES:

A. The following details the requirements of each employee's vaccination status.

1. Measles Vaccine – measles vaccine is mandatory for all employees. Two doses of vaccine administered on or after the first birthday provides adequate immunity. Immunity consists of documented receipt of two doses of live measles virus vaccine, laboratory evidence with numerical immunity, documentation of physician diagnosed measles or birth before 1957. A blood test will be provided only for those employees who are 40 years of age or older. Any employee who needs the vaccine may receive it by seeing the immunization nurse. Vaccine will be administered in combination with mumps, and Rubella according to clinic protocol. Documentation will be kept in the employee's personnel medical record in the staff development office.

2. Rubella Vaccine – Immunity to Rubella is mandatory for all employees. Immunity consists of documented receipt of one dose of live rubella virus vaccine or laboratory evidence with numerical immunity, or birth before 1957; except women of childbearing age who could become pregnant. The name of the lab and the date of the test must be on the copy. Any employee who needs the vaccine may receive it by seeing the immunization nurse. Blood test will be provided only for those employees who are 40 years of age or older. Documentation will be kept in the employee's personnel medical record in the staff development office.

3. Tetanus/Diphtheria, Pertussis – Get a one-time dose of Tdap as soon as possible if you have not received Tdap previously (regardless of when previous dose of Td was received). Get Td boosters every 10 years thereafter. Pregnant healthcare workers need to get a dose of Tdap during each pregnancy.
   Tdap (tetanus, diphtheria, pertussis) (/vaccines/vpd-vac/pertussis/recs-summary.htm)

4. Flu Vaccine – All employees will be offered a flu vaccine and may receive the vaccine, when instructed, by seeing the immunization nurse. Vaccine will be administered according to clinic protocol. Documentation will be kept in the employee's personnel medical record. All Employees that do not wish to take the annual flu vaccine must sign a "Declination of Flu Vaccine Form". This form will also be scanned into the employee's medical record.

5. Employee PPD's – Within 30 working days of employment, all new employees will undergo screening for Tuberculosis or provide a copy of their Quantiferon-TB Gold lab results. Unless a negative Quantiferon-TB Gold lab result is provided, a PPD will be given to all new employees.

   a. The employee should provide documentation of PPD within the past 12 months or they will need a second step. (Documentation consists of record stating type test, date administered, date read, measurement in millimeters, provider). If employee has a negative recorded in the past 12 months, they will receive a second step TB skin test upon hire. If the new hire has not had a documented TB skin test within the past 12 months a TB skin test will be planted upon hire and a second TB skin test will be planted at least one week thereafter.
   b. The employee has a documented history of a Positive PPD (> 10mm in diameter). Employee must provide documentation which consists of a record stating type test, date administered, date read, measurement in millimeters, dates of preventive treatment, if applicable, medication, provider, copy of a negative chest x-ray since PPD converted and a completed record of tuberculosis screening (DHHS 3405) completed using the most recent chest x-ray report.
   c. Employees with a previously documented positive TST should be re x-rayed only when symptoms for tuberculosis disease are present.
   d. The employee has a history of Tuberculosis disease. The employee must provide documentation he/she does not have

active Tuberculosis prior to assuming his/her job duties. Documentation is to include date of diagnosis, dates, and types of treatment (specific drugs) including any side effects or drug toxicity, presence of signs and symptoms of active Tuberculosis (chronic cough, production of bloody sputum, fevers, night sweats, weight loss), dates and results of last chest x-ray, dates and results of last sputum smears and cultures. This information is gathered on a screening form. Any deviations from normal will require follow-up with the communicable disease nurse. PPD's will be administered and read according to clinic protocols. Documentation will be kept in employee's medical record.

6. Hepatitis B – Within 30 working days of employment, the vaccine will be offered to all employees who are categorized as performing tasks that involve potential for mucous membrane or skin contact with blood, body fluids, or tissues, or potential for spills or splashes of them.

   a. The first dose of vaccine will be made available to employees, who have had occupational exposure, within 30 working days of initial assignment, unless the employee has previously received the complete Hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.
   b. Hepatitis B vaccine can be administered at the same time as other vaccines with no interference with antibody response to the other vaccines.
   c. If the vaccination series is interrupted after the first dose, the second dose should be administered within 1 month or as soon as possible. The second and third doses should be separated by an interval of at least two months. If only third dose is delayed, administer as soon as possible.
   d. Health Care Provider who have contact with clients or blood and are at ongoing risk for percutaneous injuries should be tested 1-2 months after completion of the 3 dose vaccination series. This applies only to the new employees that have initiated and completed their series at the Division of Public Health Services. This does not include new employees that have already completed their series prior to employment.

      - Persons who do not respond to the primary vaccine series should COMPLETE A SECOND 3 DOSE VACCINE SERIES.
      - When revaccinated retest after the second series.

- Persons who prove to be Hbs Ag – positive should be counseled how to prevent HBV transmission to others and regarding the need for medical evaluation.
- Non-responders to vaccination who are Hbs Ag negative should be considered susceptible to HBV infection and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parental exposure to Hbs Ag positive blood.

e. Booster doses of Hepatitis B vaccine are not necessary, and periodic serologic testing to monitor antibody concentrations after completion of vaccine series is not recommended.

f. Any blood or body fluid exposure sustained by an unvaccinated, susceptible person should lead to the initiation of the Hepatitis B vaccine series.

g. Employees who decline Hepatitis B vaccine are required to sign a Hepatitis B Vaccine Declination Form, and have the option of taking the vaccine at a later date if occupational exposure continues.

h. Employees having received HBV prior to employment with the Division of Public Health Services must supply documentation of dates received.

i. To comply with Standard Operating Procedures for Prevention of Disease(s) caused by Bloodborne Pathogens the Division of Public Health Services has developed written exposure determinations and maintains a list of all job classifications in which employees have occupational exposure to bloodborne pathogens. All job tasks and procedures are classified into one of three categories to facilitate exposure determination.

<u>Exposure Determination includes</u>:

Category I: Tasks that involve potential for mucous membrane or skin contact with blood, body fluids, or tissues, or potential for spills or splashes of them.

- Nursing Management
- Health Professional Students
- Lab Technicians
- Physician
- Physician Extenders
- Registered Nurse, Licensed Practical Nurse
- Medical Office Assistant

- Dental Hygienist
- Cleaning Staff
- Dentist

Category II: Tasks that involve no exposure to blood, body fluids, or tissues, but employment may require performing unplanned Category I tasks.

- Environmental Health Staff

Category III: Tasks that involve no exposure to blood, body fluids, or tissues, and Category I tasks are not a condition of employment.

- Administrative Staff
- Nutritionist and WIC Staff
- Management Support Staff
- Social Worker
- Health Educator
- Foreign Language Interpreter
- Pharmacist, PAP Staff

7. Varicella – Staff working directly with pregnant women are assessed for varicella immunity per the CDC Guidelines. If staff are non-immune they are offered a varicella titer/vaccine and documented in the personnel record prior to contact with the public.

Rev/di

Declination of Influenza Vaccination

My employer or affiliated health facility, Rockingham County Division of Public Health, has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients/staff from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear.
- My shedding the virus can spread influenza to patients/staff in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including:
    - all patients in this healthcare facility
    - my coworkers
    - my family
    - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

_____

_____

_____.

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____

Department: _____

**ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY**

TITLE: STAFF ORIENTATION/STAFF DEVELOPMENT PLAN

DATE DEVELOPED: 5/00
REVIEWED: 6/18; 9/18; 6/19; 10/19; 6/20; 6/21; 6/22; 6/23; 2/24; 6/24
REVISED: 9/18; 10/19; 2/24

I. POLICY:

Staff employed with the Division of Public Health Services will have a thorough orientation designed to ensure competency in his or her job function. Orientation will begin the first day of employment and will be completed by the end of the 6-month probationary period.

II. PURPOSE:

To orient staff to the philosophy, services, policies and procedures of the Division of Public Health Services and to their respective roles.

III. GUIDELINES:

A. The Program Director/Supervisor will ensure that all prerequisites for professional employment have been met prior to scheduling a staff member for hire.

Licensed staff will be currently licensed by the state of North Carolina and preferably have at least one year of experience in their profession.

B. A transcription of college credits may be required prior to making an offer for employment.

C. The Program Director, Supervisor or designee will conduct the beginning orientation phase. All new staff employees will meet with Human Resources before beginning orientation with the Division of Public Health. The General Orientation with the Division of Public Health Services will be conducted by the Division of Public Health Services' Personnel Technician and Staff Development Coordinator. Orientation will include the following but is not limited to:

1. General Orientation – Mission/Vision

2. OSHA-Blood borne Pathogens, fire-tornado safety, hazardous material training relative to their job setting and duties and emergency preparedness.
3. CPR course if needed (unless medically exempt).
4. Review of Confidentiality and HIPAA Regulations
5. Cultural sensitivity/diversity and nondiscrimination, health equity/disparities
6. Orientation may include state training or courses. These are defined more specifically within each program area policy.
7. A brief overview of all departments in the agency and their services.
8. Program Discipline Specific Orientation Checklist or Program Discipline Specific Competency Skills Checklist if required.
9. The new employee will attend one County Orientation which is conducted every 1st Wednesday of each month.
10. Policy overview
11. Accreditation
12. Quality improvement process
13. Time study/Payroll completion

D. Staff may participate in the following, in addition to the items listed above:

1. It is the responsibility of each Program Director/Supervisor to initiate the program discipline orientation checklist. It is appropriate for a program preceptor to be assigned. However, it is the responsibility of the Program Director/Supervisor to begin and complete the orientation checklist with the new employee. Assistance in the completion of an individualized competency based education orientation program that may include:

   - behavioral objectives for each discipline hired
   - review of liability coverage if clinical staff member
   - theoretical concepts as a basis for decisions in practice
   - assessment of discipline specific skill competency
   - appropriate administrative/clinical policies and procedures
   - general reimbursement information pertaining to each program area
   - client rights and responsibilities
   - client complaints
   - documentation of service requirements
   - services by other staff members to facilitate coordination and appropriate referrals or follow-up within the program area
   - mobile telephone usage
   - job description review, including service responsibilities – sign & date- acknowledges understanding
   - infection control policies and procedures

- identification, handling and disposal of hazardous or infectious waste in the safe and sanitary manner and in accordance with law and regulation
- community resources available to assist or extend program services
- equipment management, including safe and appropriate use of equipment as applicable to the services provided
- storage, handling and access to program supplies and equipment, drugs and medical gases appropriate to the services provided
- standing orders per clinical programs
- staff safety including worksite, driving and personal - county orientation
- guidelines for appropriate referrals, including timeliness
- any specific procedures/services to be performed by staff
- personnel policies
- screening for abuse and neglect, appropriate for the staff member's role and responsibilities
- a discipline specific orientation checklist
- personal appearance policy or discipline specific competency checklist
- county vehicle policy
- staff development, quality assurance, continuing education
- program eligibility guidelines and billing/encounter forms public health laws, rules, ordinances, discussed within the program policies, and General Statutes are assigned as applicable.

2. The orientation checklist should be completed with the new employee's understanding and thorough review of each entry listed.

3. Each entry should be dated and initialed by the supervisor **or designee**. Review of entries may be performed by a preceptor. However, the Program Director/Supervisor should ensure understanding from the new employee.

4. The orientation checklist should be given to the RCDHHS Personnel Technician for filing in the employee's training record.

5. Identify strengths and weaknesses in skills.

6. Design opportunities for remedial training – training may consist of off-site preparation and hands-on supervised training.

7. Clinical and didactic learning experiences.

E. Completed competency assessments will be given to the RCDHHS Personnel Technician for filing.

1. Staff will satisfactorily demonstrate each critical proficiently skill as listed on the procedure checklist prior to providing service independently and annually at the time of the employee's performance evaluation.

2. The Program Director/Supervisor or the Staff Development Coordinator will assess competencies. The staff member will need to satisfactorily complete each competency listed prior to individualized performance of duties.

F. Each employee will be assigned a preceptor as determined by the Program Director/Supervisor. The preceptor will be of equal or higher classification as the new employee, however, proficient within the program area.

1. The preceptor documents the employee's progress and participation on the orientation checklist by providing the preceptor initials and date.

2. The responsibilities of the program director/supervisor or the preceptor during the **one-year** orientation phase include:

   a. Instructing the new hire on policies/procedures, explaining procedures and demonstrating skills needed during program services. The new employee will review the manuals and sign verification of their review.
   b. The clinical professional new employee needs to print, sign their signature and title for filing in the Nursing Manual Section CHR 14 located in The Director of Nursing's office.

3. Staff member will be observed by the preceptor for completing skills.

4. Program Director/Supervisor or preceptor accompanies and observes new hire while providing services to observe and document any area of strength/weakness.

5. Preceptor serves as a resource person to the new hire.

6. The supervisor may assign a preceptor to instruct and train the new employee in a specific role or within the program entirety. The preceptor may be able to discuss certain data, but ultimately it is the supervisor's role to inform the new employee of this information.

   This Orientation Checklist should be completed by the end of the employee's **one-year** probationary period.

   This Orientation Checklist for the new employee should be filed by the Program Director/Supervisor once completed. It is filed in the employee's training record in the RCDHHS personnel technician's office.

7. COMPETENCY SKILLS CHECKLIST:

   a. The supervisor or preceptor is responsible for completing items under their supervision.
   b. Competency Skills Checklist should be completed by the end of the employee's **one-year** probationary period.
   c. Competency Skills Checklist is then filed by the supervisor in the employee's personnel file within the program area.
   d. Discipline Specific Checklist is reviewed and updated annually at the time of the employee's performance evaluation.

8. The orienting new employee is assigned to the specific area for hire, with the experienced staff member providing services and continuing the teaching process and assessment of skills.

   For the home visiting staff, the supervisor will make an assessment or a first visit during the orientation phase.

G. Staff will be provided with the following in addition to the items listed in #1 above:

1. Assist in the design of an individualized competency based education orientation program, which will be filed.

2. Identify strengths and weaknesses in skills appropriate for their position.

3. Design opportunities for remedial training.

4. Be provided with didactic learning experiences.

5. The strengths and weaknesses of the workforce will be discussed during an administration meeting to improve services and build agency collaboration.

6. It is recognized that initial training and orientation will vary from program to program. The essential elements required are based on state, federal, or local regulations within the program area.

H. Outside agencies may be used in orientation of all staff as needed.

I. Employees transferred from other departments of the organization will undergo the same orientation as a new employee, except that portion that is offered as part of the general orientation.

J. Cross training, promotions and changes in duties will be handled as self-directed learning experiences. The employee will be thoroughly oriented to any aspect of his/her job with which he or she is not familiar. Of necessity, such orientations will be highly individualized.

K. The minimum orientation will be 4 weeks in length to allow for synthesis of didactic information and actual practice of skills. It is expected that the employee will assume responsibility for the majority of his/her duties after 4 weeks. (This expectation is individualized to meet the employee's needs.) Some new employees may be prepared to function independently prior to the completion of 4 weeks. Some employees or program areas may require a state regulated orientation phase that extends beyond 4 weeks in order to complete required processes. This requirement is individualized per program standards.

L. The orientation program is designed for flexibility so that each employee can progress at his/her own speed, using learning resources most suitable to his/her learning style.

M. Orientation is based upon programmatic standards and state guidelines. All orientation activities include synthesis of these regulations and guidelines.

N. All documentation of competency orientation (except incomplete checklists) will be filed in the employee's personnel file after orientation.

1. Procedures not verified during orientation due to a lack of opportunity within the client population will be completed as soon as practical and documentation will be added to personnel files at that time.
2. Any procedure that has not been checked cannot be assigned until verified during the course of employment when the skill can be observed.

O. A program preceptor will be assigned to the new staff. The supervisor will assign duties after the employee has completed their orientation period with the preceptor.

P. Each new employee will complete a **one-year** probationary period. At the end of this time, a Performance Appraisal will be completed by the employee's supervisor. If performances are unacceptable, the supervisor will discuss this with the employee throughout the course of employment. The probationary period may be extended to nine months at which time a second Performance Appraisal will be completed. If the employee performs unsatisfactorily, termination may be determined.

Q. Clinical staff members may be oriented to new procedures, equipment or treatment while in the program area or in the community.

R. The program supervisor/director will annually evaluate the training and continuing educational needs of the agency and staff. The employee's job

description will be updated at the time of the annual evaluation. The employee will sign the job description when revisions are completed.

S. If any training needs are found during the annual evaluation, the staff member will have the opportunity to complete the training needed. Training is provided for all staff when funding and resources are available.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PROCUREMENT CARD

DATE DEVELOPED: 8/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/20; 6/21

I. POLICY:

Rockingham County Procurement Card Program was established to provide a more efficient and cost-effective method of purchasing and paying for small dollar purchases.

II. PURPOSE:

To establish a methodology for use and to define the limits of Rockingham County's Procurement Cards provided only to authorized personnel in order to purchase goods and materials required by Rockingham County.

A. The health department is responsible for a total of six procurements cards.

B. The Health Director is cardholder of an assigned card, and the Accounting Specialist is cardholder for the remaining five cards. Both employees are required to sign a Cardholder Agreement regarding use of the Rockingham County Procurement Card Program.

C. The five departmental cards are assigned to the following sections within the department: Administration, Environmental Health, Dental Clinic, WIC, Nursing and Health Director.

D. Employees who request use of procurement cards are first required to sign a cardholder agreement regarding the use of the Rockingham County Card Program. Employees should submit a completed, signed and approved Department requisition indicating the purpose for the use of the card.

E. Supervisors are responsible for verifying the availability of funds as listed on the Weekly Allocation Report prior to submitting the requisition to administration.

F. Staff is approved to use the card assigned to their individual section only.

G. Designated cards may not be substituted for another card. However, the Administrative Card may be substituted if a section card is already signed out.

H. If a section card and the Administrative card are signed out simultaneously, advise the employee that they may discuss with their supervisor to determine other means to secure payment for reservations and other approved uses of the procurement card.

I. Registration fees will be paid by check. Please allow three (3) weeks to process prior to date of workshop unless time frame is limited.

J. The employee must sign for the card and include the date received and the date the card is returned on the sign-out sheet provided for each card.

K. Give the employee a copy of the procurement log to complete and sign. Include the following information on the log – Date Ordered or Purchased, Vendor, Description, Amount, Name of County. The supervisor should approve all procurement card logs before submitting to accounts payable.

L. Purchases over $499.00 are not to be made using procurement cards except in the case of lodging expenses which can exceed that limit.

M. Gasoline should not be purchased with a procurement card except in the case that a vendor will not accept the fuel card assigned to that vehicle.

N. During the month of June, purchases with the procurement card will be restricted to facilitate Fiscal Year-End closing. Careful planning is required to ensure that appropriate levels of supplies are on hand to last until the beginning of the new fiscal year.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: REQUESTS FOR PAPER COPIES

DATE DEVELOPED: 5/03
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/19

I. POLICY:

To provide copies of individual medical records upon request by the client, and to provide copies of environmental health services information requested by the public.

II. PURPOSE:

To establish a reasonable cost for the equipment and materials used to make copies.

III. GUIDELINES:

Requests for Client's Protected Health Information:

1. If client requests copies in person, advise them of the price per copy (.15 cents)
2. Verify the purpose of the request for copies.
3. Provide, explain and complete as necessary a Client Authorization to Permit Use and Disclosure of Protected Health Information.
4. Review the completed authorization with the client
5. The authorization is signed and dated by the client.
6. Give a copy of the authorization to the client and scan a copy in the EHR.
7. Advise the client it may take up to 30 days to receive multiple copies.
8. Collect fees and issue a receipt of the cost of the copies and give to client.
9. Place fees collected in cash drawer box.

Request for Environmental Health Services Information:

1. The public may request copies of property maps, former applications to construct, completed authorizations, plat maps, etc., from the environmental health division without the permission of the property owner.
2. If public requests copies in person, by fax, or by mail, advise them of the price per copy. (.25 cents)
3. Collect fees and write a manual receipt for the cost of the copies.
4. Place fees collected and a copy of the receipt in cash drawer box to be submitted at the end of the day.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DEPOSITS AND CASH RECEIPTS

DATE DEVELOPED: 4/02
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 7/1/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 7/1/20; 6/21

I. POLICY:

The Division of Public Health Services collects fees for billable services from various locations within the health department. The Accounting staff receives all revenues collected and is responsible for the crediting of receipts to proper revenue or expenditure accounts.

II. PURPOSE:

To assure appropriate segregation of financial management duties and accountability for funds received.

III. GUIDELINES:

State law requires that all deposits over $250 be made daily. To maintain compliance with applicable state law, the department's Accounting Assistant or Accounting Specialist is responsible for collecting revenues and submitting a deposit slip to the County Finance Office crediting all receipts to the proper accounts.

A. Accounting Assistant balances all clinical receipts with monies collected.

1. The Personnel Technician in Administration receives checks or money orders for billable services, occupational health services, and miscellaneous reimbursements through U.S. mail and records the date received, name of the payor, the amount, the check or money order number, and the name of the individual receiving the payment. Checks and/or money orders are given to the Accounting Assistant.
2. All monies collected from the clinics are reported on separate daily cash drawer reports generated for each section.
3. From the clinic section, the daily cash deposit report includes the patient name, amount collected, and the sub-program where the monies were collected.
4. From the Prescription Assistance Program (PAP), Medication Assistance Program (MAP) and pharmacy (Rx) fees each patient receives a receipt for the amount collected.
5. The clinical cash drawer report is printed by each staff member responsible for a cash drawer. These reports and monies are given to the Accounting Assistant who is responsible for making the daily deposit. The Accounting Assistant is responsible for compiling one

report for all clinical monies collected from all cash drawers each day for balancing purposes.

6. Monies received for services rendered in the clinic are collected at 4:00 pm daily by the Accounting Assistant from the staff member who is assigned to oversee and manage these cash drawers.
7. The Accounting Assistant verifies the amount collected, and takes all monies to the Finance Office to be placed in the county safe before 5:00 pm daily.
8. The following business day morning, the Accounting Assistant retrieves the monies from the Finance Office from the previous day's collection and adds any additional monies collected after 4:00 pm from the previous day, (these clinic receipts are picked up by the Accounting Assistant between 8:00 am and 8:15 am.)
9. The Accounting Assistant reviews the sub-programs on the cash drawer report for clinical services and matches the programs to the individual receipts for accuracy. Each collection report should be signed by the staff member who collected the payment. The Accounting Assistant initials each cash drawer report total to be deposited indicating verification of posted cash receipts.
10. The monies posted are separated by program account, and a deposit slip is completed, signed, and taken to the Finance Office daily by the Accounting Assistant.
11. All returned checks from the Finance Office stamped with "NSF, Return-Account Closed", etc., are given to the Billing Office. The Billing Office will contact the client to determine if the client will be bringing a money order, certified check or cash to replace the returned check.
12. If the client chooses to make the payment by money order, or cash, the payment is processed through the health department accounts receivable system. The Accounting Specialist or Accounting Assistant shall advise the Finance Office personnel the status of payments collected due to returned checks.
13. The Billing Office will make a copy of the returned check, include documentation of the re-payment, initial the copy, and forward to Accounting Assistant for filing with the deposit.

B. Safeguarding of assets to assure cash, checks and other funds are properly secured by the department until the daily deposit is made.

1. Ten petty cash funds are maintained for the purpose of making change from fees collected in each of the following sections: clinical, pharmacy programs, and dental clinic programs. Payments received are placed in zippered money bags by staff members who are assigned to oversee and manage these funds.
2. These funds are locked either in a metal cash box and placed in a locked metal file cabinet or a locked desk drawer. Keys to the file

cabinets and desk drawers are assigned to the responsible staff and a second key is maintained in the Administrative section.

3. A petty cash box containing $50.00 in cash is maintained in the Administrative section by the Accounting Assistant to reimburse employees for small cash purchases. Reimbursement requests totaling $10.00 or more are processed through the Department's accounts payable system. Health department employees are required to submit a signed receipt designating the program and with approval by their supervisor in order to receive reimbursement.
4. A petty cash fund in the amount of $400.00 is maintained for the purpose of making change for the clinics and pharmacy programs needing to exchange large bills for smaller bills. Effective July 1, 2020, due to the limited ability to provide change, we will no longer accept bills larger than $20. In order to properly balance the cash boxes in the clinical section and to segregate the duties of the accounting staff, the funds in this petty cash fund have been divided as follows: $100.00 is maintained in the Accounting Assistant's office and $300.00 has been placed in a second locked cash box that is also maintained in the Accounting Assistant's office. The cash box must maintain a minimum of $100.00 for the next exchange in the clinic. The cash box is kept in a locked file cabinet. Any discrepancies are investigated immediately by the Accounting Assistant and reported to the Accounting Specialist.
5. All petty cash funds are periodically audited by the Accounting Specialist. (see procedure for audit)
6. Audits of all cash boxes occur at the request of the Finance Department. The Accounting Assistant is responsible for assisting with deposits along with the Accounting Specialist facilitating these audits when requested. Two audits are scheduled per year at a minimum.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PERSONAL APPEARANCE

DATE DEVELOPED: 2/95
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22 6/23; 6/24
REVISED: 6/15; 6/17; 6/18; 6/19; 6/22

I. POLICY:

The Division of Public Health Services and Rockingham County Government expects all employees and volunteers to present a positive professional image that maintains a workplace environment that is well functioning and free from unnecessary distractions and annoyances. Employees and volunteers are expected to maintain a neat and clean appearance that is appropriate for the workplace setting and for the work being performed. This policy is designated to enable employees, volunteers, and supervisory staff to meet the expectations of the Board of Health and Human Services and the County.

II. PURPOSE:

To establish a dress code that will be consistent for each employee and that is compliant with the County's *Dress Code: Attire and Grooming Policy.*

III. GUIDELINES:

A. This policy consists of a general policy statement, followed by specifics outlines for individual sections of the Department. Employees and volunteers should read both the general policy and the specific policy outlines for their section. The general appearance guidelines are to be followed unless individual section policy permits exceptions or offers more stringent guidelines. All items in the Rockingham County Policies and Procedures, "Dress Code: Attire and Grooming Policy" will be required. The policy authorizes department heads to determine and enforce guidelines for workplace-appropriate attire and grooming for their areas.

B. All employees and volunteers are expected to present a professional, businesslike image to clients, visitors, customers and the public. Acceptable personal appearance, like proper maintenance of work areas, is an ongoing requirement of employment with Rockingham County.

C. Supervisors should communicate any department-specific workplace attire and grooming guidelines to staff members during new-hire orientation and evaluation periods.

D. At the discretion of the department head, in special circumstances, such as during unusually hot or cold weather or during special occasions, staff

members may be permitted to dress in a more casual fashion than is normally required. On these occasions, staff members are still expected to present a neat appearance and are not permitted to wear ripped, frayed or disheveled clothing or athletic wear. Likewise, tight, revealing or otherwise workplace-inappropriate dress is not permitted.

E. The Division of Public Health Services and Rockingham County recognizes the importance of individually held religious beliefs to persons within its workforce. The County will reasonably accommodate a staff member's religious beliefs in terms of workplace attire unless the accommodation creates an undue hardship or creates safety issues for staff members. Those requesting a workplace attire accommodation based on religious beliefs should be referred to the human resources (HR) department.

F. The Division of Public Health Services has adopted business casual or dress-down days in compliance with the County's *Dress Code: Attire and Grooming Policy* that defines appropriate casual attire as the following:

Slacks/Dresses/Skirts –

1. Khakis or corduroys
2. Jeans (must be clean and free of rips, tears and fraying; may not be excessively tight or revealing)
3. Capris
4. Skorts/Dresses/Skirts (no shorter than 3 inches above the knee).
5. Leggings - Only if worn with a dress or tunic style top

Shirts –

1. Oxford, Polo collar knit or golf shirts
2. Company logo wear
3. Short-sleeve blouses or shirts
4. Sleeveless blouses or shirts (shoulders must be covered)
5. Turtlenecks
6. Blazers, sport coats, jackets, or sweaters

Shoes - (no heels or open-toed shoes allowed in the clinic areas)

1. Boating or deck shoes, moccasins
2. Boots, flats or sandals (open or closed toe)
3. Dress shoes, heels or pumps (open or closed toe)

G. Appropriate Grooming for Men and Women

Employees and volunteers are expected at all times to present a favorable personal appearance, including grooming and hygiene standards, in the performance of their responsibilities. Cleanliness and grooming is expected of all personnel.

The standards shall be in a manner that is normally accepted in similar public and private work environments. Some specific guidelines include but are not limited to:

1. While employees have a variety of hair styles and colors, extreme styles and colors (i.e. pink, blue, green, etc.) are not acceptable. Facial hair must be kept neat.
2. Heavy use of cologne or perfume is not acceptable.
3. Jewelry should be conservative and must not interfere with the ability to perform job duties.
4. Visible body piercing (other than the ear or small nose stud) is unacceptable. All other body piercings must be removed or covered while at work.
5. Visible body art and tattoos must be covered as best as they can while acting in an official capacity. Visible body art or tattoos that are offensive or depict illegal activities are prohibited. The County Manager and/or Human Resources is the sole judge of what constitutes unacceptable body art and tattoos.

H. Addressing Workplace Attire and Hygiene Problems

Violations of the policy can range from inappropriate clothing items to offensive perfumes and body odor. If a staff member comes to work in inappropriate attire, the staff member will be required to go home, change into conforming attire or properly groom, and return to work.

If a staff member's poor hygiene or use of too much perfume/cologne is an issue, the supervisor should discuss the problem with the staff member in private and should point out the specific areas to be corrected. If the problem persists, supervisors should follow the normal corrective action process.

I. Except during work related travel or performance of assigned job duties, employees shall not exhibit county/department issued accessories that bear official logos/emblems in such a manner or into any facility, establishment or gathering that could bring discredit to Rockingham County.

J. General Staff

All employees and volunteers are expected to present a professional, businesslike image to clients, visitors, customers and the public. Clothing should be appropriate for jobs assigned. All clothing should be clean, neat, in good repair and properly fitted. Agency provided identification tags are required in all areas and should be visible.

The following are not considered appropriate as external attire:

1. Crop tops, clothing showing midriffs, halter tops or open back shirts
2. Dresses, tops, shirts, or blouses with inappropriate cutouts or see through elements (unless a tank/camisole is worn underneath), or spaghetti straps (unless a top/sweater is worn with it)
3. Any garment that is commonly known or acknowledged as undergarments, sweatpants, exercise or athletic sportswear except clean tennis shoes, where determined by position (see Clinical Management Support and Environmental Health Staff guidelines)
4. Clothing or attachments to clothing with writing, offensive words or pictures
5. Clothing with advertisements or sports logos (other than company [agency or county] logo), t-shirts or sweatshirts unless on dress down Fridays
6. Beachwear, flip flops or beach style sandals
7. Shorts or jeans (unless worn on dress down days or specifically authorized) – no low rise or hip hugger pants or jeans allowed
8. Except for ears or small nose stud, employees are prohibited from displaying any form of visible body piercing such as: nose rings, brow piercing, lip piercing/tongue piercing
9. Body art and tattoos should not be visible during working hours.

Questions about the appearance policy should be directed to supervisors. It is recommended that if you are in doubt about a mode of dress that you speak with your supervisor prior to adopting it.

Supervisors may make reasonable supplements or exceptions to these guidelines depending on specific work conditions in their unit(s). At the supervisor's discretion, the employee will be required to change into more appropriate attire. However, the Health Director is subject to override these supplements or exceptions.

Employees' safety dictates that employees remove rings and/or other jewelry prior to performing any task in which the wearing of such jewelry poses a potential safety hazard to the employee (examples: moving boxes, cleaning procedures, working with equipment that has moving parts, maintenance tasks, etc.).

K. Management Support Personnel

1. Clinical Management Support (Assistants & Hygienists)

    a. Uniforms/scrubs/lab jackets should be worn in the clinical setting.
    b. Clean tennis shoes, walking shoes or pumps without heels are acceptable foot attire – no open-toed shoes allowed in the clinic areas.

2. Administrative Clerical Staff

   - Follow general appearance policy guidelines

L. Environmental Health Personnel

Environmental Health personnel function in two distinct task areas. Clothing is to be appropriate for the area in which the individual is working.

1. Institutional Area

   Dress should be acceptable for the office on days that specialists are involved in restaurant and institutional grading or other inside job assignments. Appropriate dress for these days includes a dress shirt and slacks. Women may choose from a dress shirt or blouse, with pants, skirt or dress. Knit polo shirts with the Rockingham County HHS or Rockingham County Environmental Health logo may be worn by men or women for grading, where appropriate. Footwear should be clean, closed-toe, and appropriate for the setting, such as slip resistant footwear. Lab coats may be worn during inspections to protect the specialist's clothing.

2. Outdoor Environmental Area

   Dress for outdoor assignment can be more casual and should fit the day's tasks and the weather conditions. Acceptable clothing includes Rockingham County HHS or Rockingham County Environmental Health shirts, slacks or jeans and work boots. During winter months clothing may include sweaters, sweatshirts, heavy coats, hooded coats or stocking caps. While jeans are acceptable for outdoor environmental work, they should be in good repair. If headgear is worn, it should be neat and in good repair.

M. Nursing Personnel and Clinic Staff

All members of the Nursing Staff are required to wear a uniform. Nursing staff uniform policy is more than a Health Department policy. Nursing staff uniform policy is affected by OSHA regulations and by the general field of nursing practice.

If nursing staff members are in doubt about the stated guidelines, it is the staff member's responsibility to discuss unclear areas with their immediate supervisor before adopting a specific style of uniform or appearance. The supervisor has the option to deem an employees dress as inappropriate or unprofessional.

1. <u>Uniform color/Fabrics</u>

a. Nurses/Lab Technicians/MOA's
- Uniform tops of all colors, patterns or prints are acceptable with solid pants (no denim)

b. Physician Extender/DON/CD Nurse/PHP
- will adhere to general appearance policy guidelines
- a white lab coat is required in the clinical setting

c. Interpreters
- may wear uniform/scrub attire or follow the general appearance policy with a lab jacket.

2. Uniform Styles

Scrub style uniforms or nursing uniforms are acceptable.

3. Vests/Sweaters

A vest of knitted material may be worn for added warmth. Solid color only no bulky knits – must be non-decorative (except on Holidays) and cannot be longer than lab coat.

4. Blouses/Shirts

Tailored and plain in style, without ornamentation and non-revealing. Blouses should not be tight fitting knit unless covered by jacket, vest or sweater.

5. Shoes

Acceptable footwear can be nurses' shoes, walking shoes, clean tennis shoes or pumps without high heels. Shoes must have closed toes when worn in the clinic area. Boots may be worn in cold, rainy or snowy weather. Staff are encouraged to bring regular work shoes with them on these days for use in clinic. Staff performing home visits may work in boots on cold, rainy or snowy weather and may wear sandals with enclosed toes in summer (except in areas where bloodborne pathogen exposure may occur.)

6. Agency Provided Identification Tags

Tags are to be worn at all times that nursing staff are functioning in their assigned Health Department capacity

7. Jewelry

Employees who frequently use gloves and/or are working in any clinical area should not wear rings with raised settings.

A single chain bracelet (no bangle) may be worn with the uniform. No bangle bracelets.

Necklaces are allowed if small, single chain, and should not dangle over uniforms.

8. Hair Styles

Hair should be neat, clean and well groomed.

9. Fingernails

Fingernails should be clean and well groomed to prevent glove puncture and to promote client safety.

10. Clinic Laboratory Coats

Lab coats are to be worn in the clinic, or during clinical community sites, as part of the uniform during the performance of job related duties for protection.

COLORS
White Lab Coats – doctors/physician extenders
Printed or solid lab jackets –Nurses, MOA's, Lab staff

11. Visiting personnel

Medical personnel visiting in the clinic should wear lab jackets.

12. Student nurses

Follow the uniform code of their school.

N. Non-nursing professional personnel

For the purpose of this document, non-nursing professional personnel are defined as social workers, nutritionists, WIC staff, health educators and pharmacists.

Non-nursing professional personnel should follow the general appearance policy. However, if these persons are performing tasks in the medical clinic setting, they should wear laboratory jackets.

O. Persons involved in community contact

When giving presentations in the community as a representative of the Health Department, ALL PERSONNEL may follow the general appearance policy guidelines. In addition, agency provided identification tags should

be worn that clearly identify the Health Department staff member and their title. Laboratory jackets may be worn in community presentation settings.

P. Any staff member who does not meet the attire or grooming standards will be subject to corrective action and may be asked to leave the premises to change clothing. Hourly paid staff members will not be compensated for any work time missed because of failure to comply with designated workplace attire and grooming standards.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: VITAL RECORDS

DATE DEVELOPED: 2/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/21; 6/24

I. POLICY:

It is the policy of the health department to provide sufficient staff, funds and other resources necessary for the proper administration of the local vital records registration program.

II. PURPOSE:

A. The purpose of the registration of birth and deaths protects the legal rights of those directly affected and provides a sound statistical basis for health and social planning.

B. The local registrar and his/her representatives must be knowledgeable of all laws and regulations governing his/her duties and must constantly strive for accuracy and complete registration of all vital events in the district assisting all other personnel involved in the collection of vital statistics, such as hospital staff, funeral directors, and physicians.

C. G.S. 130A-9 .0215 Vital Records

1. A local health department shall provide vital records services within the jurisdiction of the local health department. The local health director shall serve as the local registrar and shall perform the duties of that office as prescribed by law. A local health department shall establish, implement, and maintain written policies which shall include:

   a. Procedures for reporting flagrant, willful violations of the vital records law and reporting known vital events for which a certificate has not been obtained.
   b. A file of all vital records law, rules, and instructions issued by the state registrar.
   c. Procedures for the examination of birth, death, and fetal death certificates for accuracy and completeness.
   d. Procedures for returning incomplete or inaccurate certificates to or querying the persons responsible for filing them for completion and correction.

2. A local health department shall establish, implement, and maintain written policies for obtaining vital records education services from the State Registrar's Office for local registration personnel, hospital administrators, and their medical records personnel, funeral directors, medical examiners, and others involved in the registration system. The policies shall include provisions for orientation of new deputy registrars, sub-registrars, and back-up health department personnel.

D. 130A – 97 Duties of Local Registrars

The local registrar shall:

1. Administer and enforce provisions of Article 4 of Chapter 130A and the rules, and immediately report any violation to the State Registrar;

2. Furnish certificate forms and instructions supplied by the State Registrar to persons who require them;

3. Examine each certificate when submitted to determine if it has been completed in accordance with the provisions of Article 4 of Chapter 130A and the rules. If a certificate is incomplete or unsatisfactory, the responsible person shall be notified and required to furnish the necessary information. All birth certificates are implemented by using the **North Carolina Database Application for Vital Event (NC DAVE)**. All rules and laws still apply. The deputy or assistant deputy registrars have the option to review all birth certificates, fetal death reports, **death certificates** for accuracy and completion. Birth certificates, fetal death reports, **and death certificates** can be sent back to the hospitals **or funeral homes** for corrections through this system, if needed. The deputy registrar/assistant deputy registrars do not have access to make corrections; birth certificates/fetal death reports must be **returned** to the hospital. This function must be **reviewed** daily. After reviewing the **record, it is accepted for filing and affirmed to be released** to the Vital Records Branch in Raleigh.

4. Maintain records, make reports and perform other duties required by the State Registrar. See the following statutes: (1913, c. 109, s. 18; 1915, c. 85, s. 2; c. 164, s. 2; C.S., s. 7109; Ex. Sess. 1920, c. 58, s. 1; 1931, c. 79; 1933, c. 9, s. 1; 1943, c. 673; 1949, c. 133; 1955, c. 951, ss. 20, 21; 1957, c. 1357, s. 1; 1963, c. 492, ss. 4, 8; 1969, c. 1031, s. 1; 1971, c. 444, s. 8; 1979, c. 95, s. 9; 1981, c. 554; 1983, c. 1891, s. 2., 2003-60, s.1)

5. All death/**birth** certificates **and fetal death reports** will be implemented by using the Database Application for Vital Event (DAVE).

III. GUIDELINES:

The Local Registrar must adhere to the General Statutes and Administrative Codes governing the NC Vital Records.

Duties of Local Registrar or/and their appointed Deputy or Sub-Registrar – G.S. 130A-97

The local registrar shall:

1. Administer and enforce provisions of the General Statutes and Administration Codes and immediately report any violations to the State Registrar;

2. Furnish certificate forms and instructions supplied by the State Registrar to persons who require them;

3. Examine each birth/death certificate **and fetal death report** when submitted to determine if it has been completed in accordance with the provisions and rules. If a certificate is incomplete or unsatisfactory, the responsible persons shall be notified **to make any corrections**. All birth certificates, **death certificates,** and fetal death reports are implemented by using **DAVE system**. All rules and laws still apply. The deputy or assistant deputy registrars have the option to review all birth certificates for accuracy and completion. Birth/**death** certificates and fetal death reports can be released back to the hospitals **or funeral homes** for corrections through this system, if needed. The deputy registrar/assistant deputy registrars do not have access to make corrections; birth/**death** certificates and fetal death reports must be released back to the hospital **or funeral home**. After reviewing **records, it is accepted for filing and affirmed to be released** to the Vital Records Branch in Raleigh.

4. Maintain records, make reports and perform other duties required by the State Registrar.

ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: USAGE OF COUNTY VEHICLES

DATE DEVELOPED: 2/04
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 10/22; 6/23; 6/24
REVISED: 6/15; 6/18; 6/20; 6/22; 10/22

I. POLICY:

The Division of Health and Human Services" (DHHS) staff members will have access to county vehicles to perform agency services or functions.

II. PURPOSE:

A. To utilize county vehicles whenever available.

B. To maintain up-keep of county vehicles to enhance availability of vehicles.

III. GUIDELINES:

1. The DHHS provides assigned and fleet of vehicles that are available as carpool to all employees. All employees are required to have a valid driver's license and must report immediately to Administration of any change or loss of license.

    a. Assigned vehicles are for employees that provide home/field visits for off-site services that are conducted through the county.
    b. Fleet/car pool vehicles are for employees that have not been assigned a vehicle to perform off-site services (meetings, seminars, trainings) that are conducted through the county.

2. Employees are to utilize county vehicles assigned rather than using their own personal vehicle, unless administrative approval is obtained to use a personal vehicle.

3. Non-employees are not allowed to operate county vehicles.

4. Employees' family members and/or friends are not permitted to be transported in county vehicles.

5. Clients of the DHHS may be transported in the county vehicle if it necessitates and only when there are no other means of transportation available to the client. Transportation can only be provided to meet program responsibilities of the agency.

6. County car pool vehicles must be reserved for use through administration and shall be signed in/out. Upon return, keys shall be placed on the key holder. The sign in/out sheet and keyholder are located in the Administrative Assistant's office.

7. Each time a county vehicle are utilized, employees are expected to complete the County Vehicle Log Book that is located in that car. Please refer to Section IV of this policy regarding Employee Responsibilities for Vehicle Log.

8. All employees are required to visually inspect the vehicle prior to driving it out of the parking lot. This includes the tires, windshield wipers and windows, mirrors, lights, leaking fluids, and damage to the body. Report any issues to administration.

9. The employee that is assigned a county vehicle shall be responsible for obtaining the routine servicing, washing, removing trash, vacuuming, and annual inspection of the vehicle. Any servicing issues shall be reported to administration.

10. Employees utilizing car pool vehicles shall be responsible for removing trash and shall report any servicing issues to administration. Administration shall be responsible for ensuring county car pool vehicles receive routine servicing, washing, and annual inspection.

11. Employees will ensure all occupants in the vehicles are properly restrained (seat belts, car seats, boosters, etc.) while vehicles are in motion.

12. Employees must follow safe driving practices and obey all traffic laws.

13. Employees will notify DHHS of any citations received while operating a DHHS or personal vehicle. If an employee is involved in an accident, he/she must report immediately to their supervisor.

14. Employees are prohibited from the following:

    a. Operating county vehicles while under the influence of alcohol and/or controlled substances,
    b. Smoking, chewing tobacco and vaping, and/or
    c. Using a cell phone, including texting. All calls are to be made after safely moving to the side of the road, out of all lanes.

15. A gas card has been issued for each county vehicle. Employees are assigned a four-digit code to utilize the card.

    a. Employees assigned to a vehicle will be responsible for that card.
    b. Pool cars will have gas cards that should remain in the vehicles.
    c. Employees are responsible for making sure that county vehicles

have no less than **three quarters to one full** tank of gas when returned to the parking lot.

d. Gas can be purchased at any gas station.

e. When using the vehicle gas card, you will insert the card specific to that vehicle, enter your four-digit code, and enter the vehicles odometer reading.

16. Reference Vehicle Safety Review Board Policies for additional information.

IV. EMPLOYEE RESPONSIBILITIES FOR VEHICLE LOG:

1. Operators shall be responsible for recording the following information on the vehicle log (RCHD 117):

   a. Vehicle number
   b. Date
   c. Program to be charged for mileage and fuel
   d. Beginning and ending odometer readings
   e. Odometer reading at the time of refueling
   f. Name of driver
   g. Indicate "Yes" or "No" if the vehicle was taken for cleaning
   h. Indicate "Yes" or "No" if the oil was changed
   i. Notify supervisor and administration when scheduled servicing is due
   j. Comments are for reporting the condition of the vehicle and any repair work that has been completed or needed. Major repairs should be reported to administration in order to obtain cost of repairs and confirmation for repairs.

2. First Aid Kits should be available in all county vehicles. In the event an employee must use the First Aid Kit, he/she is responsible for reporting to the Clinical Charge Nurse for replenishment of its contents.

V. APPENDIX:

Forms:

Rockingham County Health Department Vehicle Log (RCHD 117)

Rockingham County Health Department Vehicle Log

Vehicle Number _____ **Service Due: Y ____ N ____** **Month/Year _____**

Place and Purpose of Travel	Date	Program to Charge	Odometer Reading Start		End	Total Miles Traveled	Driver's Name	Vehicle Cleaned Y/N	Comments About Condition of Vehicle – Advise Responsible Person

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CAR SUPPLIES

DATE DEVELOPED: 2/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17

I. POLICY:

The Division of Public Health Services staff members will be provided with specific equipment and supplies required to perform discipline specific job related tasks and/or skills for home related services.

II. PURPOSE:

A. To facilitate the provision of quality care and requested services.

B. To provide services in a timely, cost-effective manner.

C. To insure cleanliness of supplies and prevent supply loss due to expiration.

III. GUIDELINES:

Nursing

See listings below maintained by staff in county vehicles:

A. Nursing

- Disposable CPR mask
- Nursing Bag
- Infant scales (when needed)
- Hand Sanitizer
- Blood Pressure Cuff
- Stethoscope
- Thermometer and Sheaths
- Alcohol pads
- Cavicide Wipes
- Disposal Gloves
- Paper towels

B. Environmental Health

- Augers

- Probes
- Flags
- Laser Plane, Leveling System and Accessories
- Cell Phones
- Measuring Tape
- Water Supply Kits
- Hard Hat
- Safety Glasses

C. Health Education (as needed)

- Program Educational Materials
- Display Boards
- Projectors
- Power Point Equipment
- Lap Top
- Portable table (card size)
- Rolling cart to carry supplies

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: POLICY ON POLICIES

DATE DEVELOPED: 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17

I. POLICY:

The Division of Public Health Services addresses health promotion and disease prevention issues, community services, client care, health education programs, dental and pharmacy services, WIC services, and Environmental Health services and will strive to maintain regulatory compliance in providing services through the establishment of policies and procedures.

II. PURPOSE:

A policy is an agreed-upon course of action for being able to identify circumstances and provide the course of action needed in order to accomplish the intended goal.

III. GUIDELINES:

A. The Division of Public Health Services strives to develop policies and procedures according to:

1. Federal Government Health Care Legislation and Funding
2. State Government Acts in accordance with Federal Legislation
3. Local ordinances and rules
4. Local government provides for mandated services and may make the decision to participate or not in the services.

   The local government decision may be made at several levels:

   a. Board of County Commissioners
   b. Board of Health and Human Services
   c. Local Health Department/Health Director
   d. Program Area/Programmatic regulated state, federal and local guideline

5. Annual program contracted agreements submitted through the consolidated agreement between the State of North Carolina and the Division of Public Health Services.
6. Other related legislation/regulations which may be considered when developing policies are:

a. Board of Nursing regarding Licensure
b. Nurse Practice Act
c. OSHA regulations
d. CLIA regulations
e. Board of Pharmacy regarding dispensing medications
f. Medical Board
g. Dental Board
h. Rockingham County Attorney
i. Rockingham County Personnel Policies
j. Dentistry Regulations
k. WIC State Guidelines

B. Reasons to establish policies are:

- To provide a way to prove a standard of care
- To provide a way to improve a standard of care
- To affect safe practice
- To affect accountability
- To inform staff of the components of a quality assurance program
- To establish staff expectations of self and others
- To provide a framework for consistency in methods of practice
- To set procedural standards of practice

C. Types of policies and procedures.

1. Agency Policies

- A broad description of what the agency does and why.
- Include the objectives, rules, and regulations, which guide organizational activities and direct allocation of resources.
- Should be consistent with Agency mission statement.

2. Program Policies

- A description of what and why as they apply to individual programs.
- Includes the objectives and rules, which direct a specific program focus and activities.
- Should be consistent with overall agency policies.

3. Procedure

- Detailed description of how and by whom (discipline/position) the work is to be done.
- Should be consistent with policy statements

D. How to establish agency policies and procedures.

1. Include all disciplines or staff members who will be affected and who are involved in carrying out the program.

2. Involve Medical consultant and/or program supervising physicians when developing medical policies and procedures related to clinical services.

3. Write in clear, understandable terms.

4. Write in very straightforward, sequentially logical order, and state very clearly who does what, how to do it, and when to do it.

5. Name and number each page.

6. Policies may be reviewed by the County Attorney, County Manager or Personnel Officer, Medical Advisor, Board of Health and Human Services or other individual. Annual review of policies will be completed by supervisory staff or mangers with revisions completed. There should be a designated system for the individual reviewing and approving the policy, and the date approved. In accordance with Agency policy, this system may be on a separate page, indicating approval of all policies in the manual, or signatures may be used.

7. Policies should reflect the desired intention or may specifically state the desired outcome.

8. The agency policies may also be reviewed by:

    a. Staff
    b. Board of Health and Human Services
    c. County Legal Department
    d. Medical Director
    e. Program State/Regional Consultants
    f. Consulting Physicians

9. New programs or changes in program policies are based on internal decisions evidenced by subjected data to support the new or changed policy, and/or through external proposals and changes such as Federal, State changes, community needs, contractual agreement data submitted by the State or through budgetary funding availability.

10. All Division of Public Health Services' Policy Manuals should be kept consistent among all programs. Programs should not store additional information within the manuals.

11. Changes in policies will be made in red, dated and signed by the supervisor/program coordinator identifying the change. When policies are reviewed annually by administration, changes will be

finalized at that time. If changes are completed electronically, a copy with the changes highlighted in yellow are sent to be corrected and then reviewed by the administrator. All previous year's changes are bolded for easy identification in the new fiscal year policies.

Final review and revisions are made annually throughout all program policies, preferably at the end of the current fiscal year and prior to implementing for the beginning of the next fiscal year.

12. The staff development coordinator will keep manuals updated.

E. Policy and Procedure format

1. The name of agency

2. Title of policy

3. Date DEVELOPED - date of new material developed
REVIEWED - date material was reviewed
REVISED - date material was revised, changed

4. I. Policy - Statement about the intent of the policy.
II. Purpose - The reasons why this policy has been developed and what its purpose will be to the agency.
III. Guidelines - Content identified to explain the specifics related to the title.

F. Review and approval of policies:

1. Policies and procedures should be reviewed during orientation, annually, and as changes are made and identified in bold print. The Staff Development Coordinator ensures that all employees sign in the Policy, OSHA, and HIPAA Review Book annually.

2. Revisions made are dated, and reviewed with the staff through email, memos and program unit meetings.

3. When policies are revised, the designated person within the program retains an original of the outdated copy of the policy in the agency. These originals are maintained until the next accreditation period to show changes that were made.

4. The Medical Director and/or the consulting physician may review, sign and date the policies and procedures manuals as indicated or as new policies are developed.

G. Storage and accessibility of agency policy manuals:

1. Each program area will have policy manuals easily accessible to staff at all times. Policy manuals will be stored in the Director of Nursing's office.

   Policies are accessible on the Government Center "T" Drive located in the Public Health folder. They can be viewed by double clicking on the RCDPH Policies folder. All employees have computer access.

2. Manuals are set up according to the following:

   a. Policy Manual 1
      - Quality Improvement
      - Board of Health and Human Services/Workforce
      - Billing/Accounts Receivable/Accounts Payable
      - Administrative
      - Safety
      - WIC
      - Health Education
      - Dental Clinic
      - Pharmacy
      - Environmental Health
      - Mobile Dental Unit

   b. Policy Manual 2A
      - Clinical Services/Nursing
      - Adult Primary Care
      - Child Health
      - Communicable Disease
      - Care Management for At Risk Children (CMARC)
      - Family Planning
      - Immunizations
      - Lab
      - Pregnancy Care Management
      - Pediatric Primary Care
      - Public Health Preparedness
      - STD
      - Clinical Procedures

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Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE:

DATE DEVELOPED:
REVIEWED:
REVISED:

I. <u>POLICY</u>:

II. <u>PURPOSE</u>:

III. <u>GUIDELINES</u>:

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: AFTER HOURS POLICY

DATE DEVELOPED: 1/2006
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18

I. POLICY:

The Division of Public Health Services will maintain a system in place on the main call-in switchboard that informs clients of procedures to follow during health department after hours.

II. PURPOSE:

To inform the clients of the Division of Public Health Services how to manage situations that may arise in their health care during hours in which the agency is closed.

III. GUIDELINES:

A. The normal working hours of the Division of Public Health Services are Monday-Friday, 8:00 am-5:00 pm. These hours may be extended for pertinent dental and clinic needs. These times may vary depending upon adverse weather closings or delayed openings and/or holiday, weekend closings.

B. Clients that are assigned to the Division of Public Health Services as their primary care provider through Medicaid/Medicare pay source are informed of the procedures to contact clinical personnel on-call. On-call services are provided for those clients through Carolina Access.

C. On-call coverage is provided by the physician extender and/or registered nurses on a rotating basis.

D. The on-call personnel for clinical services carry a cellular phone. The health department telephone number to call is listed on the client's Carolina Access Medicaid Card. After hours and on weekends when the client calls this number, they are instructed to another number to call. The nurse/physician extender will return the client's call.

E. Refer to the "Carolina Access – Primary Care and After Hours, Weekend Coverage Policy" NUR-21 in the Division of Public Health Services' Policy Manual 2.

F. The Environmental Health staff carries a pager for after hour spills or environmental emergencies.

G. The following staff carry a phone after hours:

Health Director	910-308-3627
Director of Nursing	336-951-7549
Environmental Health Supervisor	336-589-5088
Public Health Preparedness Coordinator	336-589-5680
Communicable Disease Coordinator	336-589-5715
Carolina Access Number	336-589-5728
Clinical Supervisor	336-932-3673

H. The Division of Public Health Services' Administrative Staff works with the IT Department to ensure that an after-hours message is available on the main switchboard. The message instructs the client to use our on-call/after-hours contact numbers.

It is also understood that the Division of Public Health Services is not an emergency facility. If the client is experiencing a medical emergency, they will be instructed to call 911.

I. The dental staff is responsible for ensuring there is an available after hour's message on their main phone line. The message should instruct clients accordingly of procedures to follow. It is understood that the dental clinic is not an emergency facility and clients with medical emergencies should be instructed to call 911.

J. All programs of the Division of Public Health Services should instruct clients of hours of operation and after hour's procedures as applicable.

K. Information pertaining to a Public Health threat or emergency situation that occurs after hours will be sent via e-mail, fax, or phone to Emergency Management Staff, local hospitals, State Lab, etc. following the Bioterrorism Preparedness policies.

L. Routine updates for after hours coverage is submitted to UNC Rockingham Health Care, Annie Penn Hospital, and Emergency Management Services to keep them abreast on numbers and staff accountable.

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**ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY**

TITLE: CONTINUING EDUCATION

DATE DEVELOPED: 10/1/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/18; 6/22

I. POLICY:

The Division of Public Health Services maintains an effective comprehensive training and education program to ensure that the constantly changing and increasing public needs can be met.

II. PURPOSE:

A. To provide necessary training and education for the Division of Public Health Services' members to enable them to fulfill the responsibilities of their positions.

B. To increase knowledge and technical competence of the skills of staff members.

C. To increase staff member competency in a specific area of practice.

D. To provide staff members with current services information.

E. To promote an environment conducive to the acknowledgement and acceptance of innovative ideas and programs by staff members.

F. To implement in-services, training and other activities for staff provided through contract and volunteers.

The Division of Public Health Services educational components include the following:

a. Orientation: the means by which new staff members are introduced to the philosophy, goals, policies and procedures, role expectations, and special services in an overall and specific work setting.
b. Continuing Education: any organized planning program under the review and direction of the Supervisor or designee in which learning experiences are designed to build upon previously acquired knowledge and skills.

c. In-service Education: any instructional or training program provided by the Division of Public Health Services in the work setting that is designed to increase its staff members' competence in a specific area of practice.
d. Incidental Learning: opportunities in the work environment that may or may not be preplanned by providing learning experiences that build upon previously acquired knowledge and skills.
e. Client education includes educational programs and services developed for clients and families.
f. Community education includes all educational programs, seminars, conferences, and forums that are developed by the Division of Public Health Services or by the agency in collaboration with other related agencies, and are open for public participation.

III. GUIDELINES:

A. The Division of Public Health Services promotes continuing education for all personnel. The training needs must be specifically job related to enhance the employee's potential growth of services.

B. Nursing: The department will provide training to prepare nurses without academic preparation, i.e., Diploma, ADN graduates, by facilitating their participation in the Introduction to Public Health and Public Health Nursing Course.

1. This course is offered in collaboration with the UNC School of Public Health Office of Continuing Education. It is required of all non-baccalaureate prepared registered nurses hired by the Division of Public Health Services and is available to any baccalaureate prepared nurses or Social Workers who wish to receive the training. This course is usually offered as a three-week course.

    a. This course should be completed by the non-baccalaureate nurse within one year of employment with the health department, or be at least in the process of taking the course when the first anniversary of employment arrives.
    b. This rule applies to all nurses without a baccalaureate degree in nursing with no exceptions.
    c. A nursing degree from another field other than nursing does not meet this requirement.
    d. The course must be successfully completed, including attaining a passing average on all tests and assignments.

2. All ADN and Diploma nurses entering Public Health are encouraged to establish plans to obtain a BSN through an accredited university. Advanced academic study for those nurses who are eligible is highly encouraged.

C. Social Worker: Social workers are required to attend within one year of hire date, the Introduction to Public Health in North Carolina Online Course at http://www.sph.unc.edu/oce/. All social workers without a bachelor's or master's degree in social work are recommended to complete within one year of hire date, the Introduction to Principle and Practices of Public Health Social Work.

IV. PROCEDURES FOR REQUESTING AND OBTAINING CONTINUING EDUCATION:

A. The agency may provide time, travel reimbursement and registration cost for workshops for each staff member as finances and scheduling allow. Those workshops attended must be relevant to the employees' specific area of work and must be discussed with immediate supervisor and approved prior to workshop date.

B. The employee who is allowed to attend continuing education offerings is expected to share any information gained with all in the specific work area as soon as possible upon return to the agency. The program supervisor should ensure this information is shared.

C. Employees are encouraged to obtain continuing education on his/her own time in order to stay abreast of current theory and practice skills for his/her own benefit.

D. Requests should be presented to the supervisor for approval. Requests will be honored on the basis of the need to know the material offered, and scheduling of the program.

1. The employee should fill out all required county travel forms to attend workshop with the information requested. This should be given to the supervisor of your program. The supervisor and the Health Director will make the approval for the need to attend the workshop. Final approval will be the County Manager or his designee.
2. Announcements regarding upcoming workshops may be posted within the agency, or directed through the supervisors.
3. Approval for workshop attendance is based on applicability of content, work demands of staff, needs of staff, and availability of funds.
4. Prepayment may be requested as time allows. In situations where there is inadequate time to arrange prepayment, the participant may submit a receipt for reimbursement of the paid registration.

5. Employees attending out-of-town workshops where overnight lodging is required will be reimbursed for incurred expenses based on submission of information and pre-approval.
6. Employees may be given county approved meal allowance per day (providing meals are not included in the registration fee).
7. This procedure must be thoroughly discussed with the program supervisor and administration for acquiring financial reimbursements.

E. Employees may maintain a log of workshops attended.

1. Each employee is responsible for completing a "Completion of Workshop Attended Form" attaching it to the request for travel reimbursement. Travel reimbursement forms are considered incomplete if training/education expense is recorded and a Completion of Workshop Attended Form is not attached. If a travel reimbursement form is not necessary this form must be completed and given to the appropriate person for accurate recording. Information required will be the date, hours, location and subject.
2. At the end of each fiscal year and/or at any time in question, the employee can view the workshops for continuing education attended as necessary for verification.

F. The agency will periodically offer in-service relevant to all areas of practice. Employees are encouraged to attend these offerings pertinent to his/her area. An attendance roster will be maintained. Mandatory training requires all to be in attendance.

Up-to-date manuals, periodicals and reference books are available online to all disciplines.

G. Continuing education time may be accrued through:

a. Workshop attendance
b. Agency In-service training
c. On the job training of new equipment, procedures, etc.
d. Through reading and written material.

H. <u>Other Educational Requirements</u>

Each program area within the health department may require additional training in order to meet the contract addenda programmatic requirements.

I. Orientation and/or Annual Continuing Education Updates:

1. The Division of Public Health Services assures staff awareness of health disparities, health equity, and social determinants of health. Cultural competency training is also included in orientation for new staff as well as annual training for existing staff.
2. CPR – current certification is required for employees who provide clinical services – AHA provides every two-year re-certification.

    a. The agency prioritizes required BCLS training in the following manner:

    - Physician Extender/Dentist
    - RN's/LPN's/dental hygienist/ assistants
    - MOA's
    - Social Workers
    - Lab Technicians

    b. Other agency staff may receive BCLS training per their request, but this is not required by the agency, (i.e., Pharmacist, Management Support, WIC, Health Education, Environmental Health, etc.)

3. Infection Control – OSHA – all staff
4. Safety – Workplace and Violence – all staff
5. Hazardous Materials – all staff
6. Confidentiality – all staff
7. Fire and Tornado Safety or drill– all staff (County or departmental)
8. HIPAA – all staff
9. Accreditation/Compliance of Program Requirements – all staff

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24.1

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OFPUBLIC HEALTH SERVICES

ANNUAL INSERVICE/WORKSHOP RECORD

This form may be used by staff throughout the year to record workshop attendance, then compare to agency records to ensure consistency.

Employee Name: _____

Fiscal Year Beginning/Ending: _____

Methods of Validation:

1. Direct Observation
2. Video Review
3. Self-study
4. Post-exam
5. Preceptor
6. Reviewed Policy
7. Presenter
8. Other

TOPIC	DATE	CEU'S OR CONTACT HOURS	ATTENDANCE HOURS

TOPIC	DATE	CONTACT	ATTENDANCE HOURS

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLINICAL RECORDS

DATE DEVELOPED: 5/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/17; 6/23

I. POLICY:

A clinical record is maintained on each client receiving services through the Division of Public Health Services. The clinical record contains pertinent past and current medical, nursing, social and other therapeutic information. All services, whether through direct client care or phone interviews, were documented in the clinical record. Each discipline or other agency personnel, whether contracted or employed by the agency, is responsible for their own documentation. Also, any interaction with the client's physician, from verbal orders to progress updates and follow-up calls should be documented in the clinical records. A note must be written for each encounter made and recorded daily. Historical clinical records are maintained in paper format. All records are currently maintained electronically.

II. PURPOSE:

To maintain the required information for each client seen through the health department in order to collaborate services and to provide a more holistic approach to their medical care.

III. GUIDELINES FOR CLINICAL RECORDS:

A. Clinical Record Chart Order:

1. To facilitate convenient and expected access to client clinical records, all active and inactive client clinical records are maintained according to a defined chart order.

2. Active and inactive client clinical records are maintained in the following chart order (any form not being used may be deleted from chart order – there should not be any blank forms in the record).

3. Each section tab below is to include forms placed in the order listed, with the first form of the section placed on top.

4. Place each documentation sheet behind the file-backed indexes.

5. Records for clients presenting for services maintain the primary indexes (this does not include clients for flu, pneumonia or TB skin tests). These charts have Problem List, Immunization Flow Sheet and consents only. Additional indexes will be added per program needs, such as communicable disease index.

6. All physicians' orders received are placed on top – behind the program index.

7. All referrals made are placed under the program that is making the referral. The "Referral Follow-Up Form" is used.

8. All documented forms must have the client's identification data listed. This includes:
   - client's name
   - MR number
   - DOB
   - the revision date and assigned form number

9. All clinical record charts must include a pre-printed sticker in the upper left corner of the chart indicating the last year of service (i.e., 08, 09, 10, etc.).

10. All clinical record charts must include a red and white allergy sticker centered on the front of the chart.

    LEFT SIDE OF RECORD – Problem List, Medication Flow Sheet/Medication Counseling Sheet on top of file back indexes.

    a. Problem List – Do not include narratives on the Problem List**.** Every clinical record maintains an updated problem list at each visit. The problems identified should be reflective of the presenting complaints. Each problem should be numbered consecutively. If the problem is resolved and later reoccurs, assign a new number and make reference to the previously assigned number.
    b. Case Management
    c. File the Tracking of Missed Appointments "DNKA" under the Problem List.
    d. Medication Flow Sheet and/or Medication Counseling Sheet – these forms are used to maintain current medications that the client is taking. All programs must use the Medication Flow Sheet and it is to be updated every visit. This includes all primary care programs**.**
    e. Section Tab: Narrative Notes – 1st Index

- Triage Sheet – placed in chronological order
- Client Instruction Sheet – placed in chronological order

f. Section Tab: Immunization – 2nd Index – Place the immunization flow sheets and master cards here.
- Immunization Narrative Notes
- Consent for Immunizations Signature Sheet
- Immunization Record – Chart Copy
- Immunization Records from outside providers/NCIR
- Immunization Screening Questionnaire Child or Adult
- Immunization/Skin Test Flow Sheet – most current on top
- Master Card on the bottom

g. Section Tab: Correspondence/Miscellaneous – 3rd Index
- Personal Data – on top – Information needs to be updated every visit
- Financial Sheet – updated every visit by registration staff- only the most current one on top
- Demographic Sheet – updated every visit by registration staff – only the most current one on top
- Referrals from other providers – On the Problem List you need to put Services Provided/Referrals from Outside Sources on bottom. (Place the most current old record on top).
- QuitlineNC Fax Referral Form

h. Section Tab: Consents – 4th Index
- Consents are grouped together
- There may be several consents per program with the most current on top
- Acknowledgement of Receipt of Notice of Privacy Practices
- Client Information Tracking Form – placed in chronological order;
  1. Client Authorization/Consent – place most current on top
  2. Health Department Cover Letter (mailed with attachments)
  3. Information received from other sources (ex; billing office, etc.)

<u>Additional Index: Left Side</u>

i. Section Tab: WIC – 5th Index - Children's Growth Chart – placed on top if it is initially completed by WIC.
- SOAP Notes Sheet (optional)

- Nutrition Care Plans (attach prenatal weight grid to corresponding care plan)
- Income Card – layered in chronological order
- Income Card Part II – layered in chronological order
- Third Party Confirmation Letter
- Transfer forms/VOC Cards

*Note: Records house only "one" growth chart. If the child is being seen by WIC and Child Health/Pediatric Primary Care the growth chart will be on the top under the WIC index. If the child is not a current WIC client, the growth chart will be placed on top under the Primary Care index.

RIGHT SIDE OF RECORD

a. Adult Diabetes Mellitus Cart Marker (if applicable) place on top of Primary Care section tab.
Section Tab: Primary Care – 1st Index - Place primary care records in date order with the most current on top. Documentation in this section is to be grouped by PROGRAM TYPE from bottom to top. Programs may include:

Adult Health
*Health Screening/Health Maintenance Form (Dr. Howard) (to remain on top)
*Physician's orders
*Referrals
*Adult Basic Health History (completed by client)
*Initial Basic Physical Exam
*Physician Extender/Nurses Narrative Notes
*Glaucoma Flow Sheet

Breast and Cervical Cancer Control Program
- BCCCP Follow-up (Pink Sheet)
- NC BCCCP Case Management Form
- BCCCP Medical History Record
- Adult Health/BCCCP – Physical Exam Form

CVD WISEWOMAN Forms
- WISEWOMAN Lifestyle Intervention Plan
- Intervention Options
- WISEWOMAN Self Report Stages of Change Survey
- Abnormal Value Sheet (if indicated)
- WISEWOMAN Medical Care Case Management (if indicated)

Child Health
*Physician's orders

*Referrals
*Growth Chart – if only seen by Child Health
*Self-History
*Initial Physical
A. Child Health Flow Sheet
B. Child/Adolescent Basic History
C. Developmental
a. PEDS/PSC
*Physician Extender/Nurses Narrative Notes
*Dental Varnish

Pediatric Primary Care
* Physician's Orders
* Referrals
* Self-History (new client/annual update)
* Physician Extender/Nurses Narrative Notes

Additional Indexes:

b. Section Tab: Women's Health – 2nd Index
Family Planning
Place forms in date order with the most current service on top.
- Referral forms
- Family Planning Continuation Sheet (every visit thereafter) (for annual physicals and return visits) as needed, most recent on top
- Initial Physical Examination (English)
- Patient Self-History Form (English)
- Family Planning Education and Needs Assessment (all new physicals)
- Colposcopy/Cryosurgery (as needed)

Forms are sectioned so that all forms are grouped with this visit date. The notes are added on top with the most current on top.

c. Section Tab: Nutrition – 3rd Index
-Referrals
-Growth Chart (if not previously started by other program)
-Nutrition Flow Sheet
-Note Sheet
-Referrals
-General Clinic Referral
-Meal Plan and Exchanges
-Diabetes Education Flow Sheet
-Dietary Assessment

-Education Pre-knowledge and Skills Assessment
-Diabetes Nutrition Chart (once the Diabetes Education Classes have been completed)
-Your Meal Plan in Exchanges

d. Section Tab: Communicable Disease – 4th Index
All forms associated with communicable disease visits are housed within this index.

- Physician's orders (chronological order)
- Referrals
- STD on top (chronological order)
- Tuberculosis Follow-up (all state forms and narrative notes)
- Hepatitis A – except for community outbreak
- Hepatitis B, C – (all state forms and narrative notes)
- Rubella – (all state forms and narrative notes)
- Etc. Any other Communicable Disease investigated

e. Section Tab: Family Care Coordination – 5th Index
These forms are housed after they are discharged from the program. The FCC Staff keeps forms within their program area until they are discharged from the program (field chart).

The program packets will be stapled together, sent to clinical records, and placed behind the FCC index in the format listed below.

<u>Pregnancy Care Management</u>
- Physician's orders
- POS (Pregnancy Outcome Summary)
- Care Coordination Record
- Intake Screening
- Abuse Assessment
- Edinburgh Postnatal Depression Scale
- Care Plans 1-28
- If skilled nursing visit: skilled nursing visit notes
- Letter of Agreement
- Release of Information
- Family Care Coordination Consent/HIPAA Consents
- Referrals

<u>Post-Partum/Newborn</u>
- Physician's orders
- POS (Pregnancy Outcome Summary) (if not completed by PCM program

- Post Partum/Newborn Home Visit Assessment
- Edinburgh Postnatal Depression Scale
- Permission for Release of Information Consent for Treatment
- HIPAA Consents
- Education Checklist (white copy/mother) (yellow copy/child)
- Referrals (if any)

Care Coordination for Children (CC4C)
During time of providing service (field chart)

Left side
- Education Checklist
- Care Plans (numerical order)
- Resolved Care Plans (last)
- Consents/HIPAA (LOA, Release of Information) (most recent on top)
- Identification and Referral, Risk Indicator (most recent on top)

Right side
- Nursing notes (most recent on top)
- Strength and Needs Assessment (most recent on top)
- Parent Child Interaction
- Immunizations
- Growth Chart (if applicable)
- Developmental Screening
- Status Reports (most recent on top)
- Miscellaneous etc. (H & P) (most recent on top)

At discharge from CC4C, staff will dismantle folder, placing left side contents on top of right side contents, secure with rubber band. Release this record to the office unit supervisor.

f. Section Tab: Laboratory – 6th Index – This index is initiated on every chart. Place all lab reports grouped together in date order by test type.
- Use regular paper and staple half-sized lab sheets – staggering as many as possible in order to flow in chronological order from the bottom to the top.
- One sheet to post identical forms. (Ex: All urines on one sheet)
- All similarities together with the most current on top

- Including x-rays, mammograms, colpo/paps, and biopsy pathology reports generated within the Division of Public Health Services.

B. Access:

1. The supervisors/Director of Nursing or the Staff Development Privacy Officer must be available when anyone other than an employee/contract staff of the agency comes to the premises to review a clinical record in order to explain and protect the clinical record.

2. Only staff members and/or contract staff involved with the direct care of a client, or involved with clinical record review may make entries in and review clinical and computer records. These include the following:
   a. Registered Nurses and Licensed Practical Nurses
   b. Social Workers
   c. Physician Extenders
   d. Medical Office Assistants
   e. Lab Technicians
   f. Women, Infant, & Children staff
   g. Administrative Personnel
   h. Billing Personnel
   i. Management Support Staff

3. Other individuals may review the clinical record on a need to know basis in accordance with the agency's confidentiality procedures. These may include:
   a. Staff Development Coordinator
   b. IOP Auditing Team
   c. Surveyors/Auditors/Consultants
   d. Attorneys
   e. Clients
   f. Third Party Payors
   g. Client's Legal Guardians
   h. Referring Physicians
   i. Legal Authorities, with a Subpoena
   j. Pharmacy and Nursing Students
   k. Guardian Ad-Litem
   l. Environmental Health Specialist

C. Active Clinical Record:

1. The original of all active records are stored in the clinical records room, or the locked Unit Supervisors office overnight. Clinical records are stored and filed alphabetically and the charts are color-coded according to the client's initials of their first name.

   a. The clinical records room is to remain locked at all times and not accessible to anyone other than appropriate agency personnel and housekeeping staff.
   b. Confidentiality of clinical record information is addressed in a signed confidentiality statement form for all staff – agency, contract, volunteers, and students.
   c. Each discipline's daily notes are maintained according to agency policies.
   d. To prevent unauthorized disclosure of record information, the home visiting staff documents medical record information, in the client's home, in their vehicle following a visit, or in another non-public location.
   f. Staff completes documentation when started. If called away from the setting, staff:
      - Closes the clinical record
      - Covers the clinical record or
      - Files are returned to the secure medical records area
      - Closes the computer screen so that no one can access or visibly acquire client information
      - Computer screens are turned away from view/or screensavers attached
      - Closes door when leaving office
   g. Clinical records are retrieved from the clinical records room if needed.
   h. As of December 1, 2016, no paper records will be created. All clinical information will be recorded in the electronic health record (EHR).

D. Records Retention and Disposition

The Division of Public Health Services maintains the Records Retention and Disposition Schedule recognized in the 2019 Local Health Department Records Retention and Disposition Schedule Manual.

IV. GUIDELINES FOR DENTAL CLINICAL RECORD:

A. Dental Clinical Chart Order:

1. Dental clinical records are maintained according to a defined chart order.

2. **Dental clinic began using Dentrix EHR in January 2016.**

3. Effective October 1, 2005, active and inactive dental clinical records are maintained in this format as returning clients present for services and as new clients are established in the following chart order:

   LEFT SIDE OF RECORD
   X-ray reports – with the most recent on top.

   RIGHT SIDE OF RECORD

   a. Patient Information Form is kept behind indexes.
   b. Section Tab: 1st Index – Insurance
      - Copy of MI, Health Choice or GAP with verification of income
   c. Section Tab: 2nd Index - Patient Registration
   d. Section Tab: 3rd Index - Health History Update
   e. Section Tab: 4th Index - Medical History Form
      This form should be addressed at each visit for any changes in patient's health history. (Any changes should be noted within the dated progress note, which is located behind the Exam Record Tab). Do not alter or delete anything to or from the original documentation. An original complete review and update will be conducted every two years.
   f. Section Tab: 5th Index –Treatment Plan
      - Treatment Plan Form reflects documentation of each visit that patient presents for treatment.
   g. Section Tab: 6th Index – Exam Records
      - Progress Notes – reflects documentation of each visit or prn on an as needed basis.
   h. Section Tab: 7th Index – HIPAA & Consent Forms
      - HIPAA Privacy Practice Consent
      - If patient is a child:
        - Child Behavioral Consent Form
        - Parent Consent Form
   i. Section Tab: 8th Index – Correspondence
      - Consents for Dental Surgery
      - Information received from outside sources

B. Access:

1. The Dentist or Staff Development Coordinator/Privacy Officer must be available when anyone other than an employee/contract staff of the agency comes to the premises to review a dental record in order to explain and protect the dental record.

2. Only staff members and/or contract staff involved with the direct care of the patient, or involved with dental record review may make entries in and review clinical and computer records. These include the following:

   a. Dentist and Dental Staff
   b. Administrative Personnel
   c. Billing Personnel
   d. Management Support Staff

3. Other individuals may review the dental record on a need to basis in accordance with the agency's confidentiality procedures. These may include:

   a. Staff Development Coordinator
   b. Surveyors/Auditors/Consultants
   c. Attorneys
   d. Patients
   e. Third Party Payers
   f. Patient's Legal Guardians
   g. Referring Dentists
   h. Legal Authorities with a Subpoena
   i. Dental Students practicing under the direction of a Dental School
   j. Guardian Ad-Litem

C. Active Dental Clinical Record:

1. The original of all active dental records are stored in dental clinic files in the front office area.

2. Dental clinical records are stored and filed alphabetically and the charts are coded with sticker of year client was last seen and first four letters of last name.

   a. Access to the dental clinical records is limited to one front door and side door.
   b. Each door remains locked and can only be accessed to open by the dental staff already residing in the dental clinic reception/treatment area.

c. Dental staff may retrieve a dental clinical record.
d. Confidentiality of the dental clinical record information is addressed in a signed confidentiality statement form for all staff – agency, contract, volunteers, and students.
e. Staff should complete the documentation when started. If called away from the setting, staff should:
- close the dental clinical record
- cover the record or
- place the record back into its original setting
- If using computer for documentation –
- close the computer screen so no one can access or visibly acquire patient information
- turn computer screen away from view
- close door when leaving office

f. Dental staff may file documentation into dental clinical record or the dental staff may place documentation within the record.
g. However, the dental staff should review the chart order of the dental clinical record prior to returning it into the file cabinet.
h. A fire extinguisher is located in close proximity to the dental clinical records for use in the event of a fire.
i. No records are stored on the floor.
j. All documentations forms within the record will have the client's identifying information.
k. At least one side of the form will contain a computer generated label.

V. TRANSPORTATION OF CLINICAL RECORDS:

A. In the event a clinical record should be required to be transported to a different location, it will be transported in a secured, locked and enclosed container out of sight of passersby.

B. This container will be transported in the trunk or the back floorboard behind the passenger seat if the vehicle does not have a trunk.

C. Failure to comply with this procedure will be considered a breach of confidentiality of protected health information.

VI. DOCUMENTATION GUIDELINES:

A. Documentation should be completed within 24 hours. Medicaid requires all documentation to be completed within 7 days.

B. Corrections in Clinical Records:

1. An eraser or ink eradicator is never used on a legal document such as a clinical record.

2. Errors on the clinical record are marked out first by drawing a single line through the incorrect information and then entering the correct information above or immediately following the entry. The initials of the person making the corrections and the date should be entered. This procedure applies to corrections in handwritten documents and in final copies of typed documents.

3. Absolutely – no white out is used.

4. Documentation is completed in black ink, unless

   a. It is indicating allergies which should be documented in red.
   b. Dental staff may document client no shows, cancellations, behaviors, or complaints in red.

5. No Post-It stickers should become permanent part of the clinical record.

C. Responsibilities of the Clinical Records:

1. It is the responsibility of the Health Director to ensure that safeguards are in place to prevent incidental and unauthorized disclosures of PHI that is created and maintained by the Division of Public Health Services. Responsibility is delegated through division directors, supervisors and other personnel.

2. The Privacy Officer is responsible to collaborate with department supervisors to design a process that will ensure that all clinical records are collected and secured by the end of each business day.

3. Program directors and supervisors are responsible for developing and providing training and support that will enable staff to comply with this policy and procedure.

4. The Division of Public Health Services workforce has the responsibility to protect the privacy of the health information of clients by complying with this policy and procedure.

VII. PORTABLE DEVICE USAGE/SECURITY FOR DOCUMENTATION OF CLIENT ENCOUNTER:

A. Password required for usage of the operating system.

B. Password required for each documentation system (i.e., Case Management Information System, Patagonia).

C. Staff maintains security by keeping device in possession during patient encounter(s).

D. At the end of each business day the device(s) are returned/secured to the agency.

VIII. CLINICAL RECORDS/FORMS COMMITTEE:

A. Members of the Clinical Records/Forms Committee:

1. The Division of Public Health Services has an internal records committee. The clinical records/forms committee consists of the following members:

   a. Director of Nursing
   b. Lab Staff
   c. Family Care Coordination Supervisor
   d. Women's Health Coordinator
   e. Public Health Preparedness Coordinator
   f. Communicable Disease Coordinator
   g. Staff Development Coordinator/Privacy Officer – Chairperson
   h. Child Health Coordinator III
   i. WIC Staff
   j. Dental Staff
   k. Pharmacy Staff
   l. Health Education Program Manager
   m. Office Work Unit Supervisor
   n. Clinical Nursing Supervisor
   o. Administration Staff Member
   p. Management Support Staff – dictation of minutes

B. Purposes of the Clinical Records/Forms Committee:

1. To establish a chart order for the clinical and dental records.

2. To ensure the review of the chart order through program internal audits.

3. To approve and implement any necessary changes in the chart order.

4. To ensure consistency of the chart order throughout the clinical and dental programs.

5. To review all forms that are used within the agency.

6. To approve all pamphlets and brochures prior to each program purchasing. This will ensure the purpose and necessity for obtaining additional pamphlets and brochures.

C. Process for Approving Forms to be Placed Within the Clinical Record:

1. The program supervisor/director will present the form to the chairperson.

2. The chairperson will schedule a date and time for the records committee to meet.

3. Committee members will be notified by the chairperson of any committee meetings.

4. The committee will review the requests and recommend approvals or non-approvals.

5. Minutes of the meeting will be maintained and filed by the chairperson.

6. The approved documents will be assigned a form number by the management support member.

7. The chairperson will return approved form to the requesting program area for ordering.

8. The program area supervisor/director is responsible for updating the program staff of the new document.

9. The chairperson will add this chart form into the appropriate program area within the clinical records policy.

D. The clinical records/forms committee will strive to meet quarterly to review maintenance and compliance of the clinical and dental records. The committee may meet more often as needed.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
Division of Public Health Services
Incident Reports

Year: _____

Date of Incident	Medical Record Number	Gender	Incident Description	Location of Incident	Action Taken: (1) Assessed by PA (2) Assessed by NP (3) Contacted 911 (4) Transported to hospital (5) Ice pack given/applied (6) No treatment necessary

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: INCIDENT REPORTS

DATE DEVELOPED: 8/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/22

I. POLICY:

The Division of Public Health Services' staff or clients involved in accidents/ incidents are treated as necessary and the accident/incident is documented as soon as possible after it occurs. The incident should be reported to the supervisor immediately.

II. PURPOSE:

A. To provide necessary and timely intervention for clients or staff when an accident or incident occurs.

B. To facilitate timely, accurate and complete documentation of all accidents/incidents.

C. To implement a quality monitoring system for accidents/incidents that is a part of the agency's overall Performance Improvement Plan.

III. GUIDELINES:

A. An incident is any unusual or unexpected occurrence that leads or could potentially lead to injury of a client, family/caregiver, or agency staff.

B. Incidents Involving Clients

1. Reportable events involve situations that occur in the presence of the staff or while the staff member is responsible for directly providing client care and may adversely affect the client's health, safety, or welfare. These may include, but are not limited to:

a. Finding the client unconscious
b. Falls, burns or other injuries
c. Medication errors, including omissions
d. Adverse or allergic drug reactions
e. Client/caregiver complaints of theft
f. Breakage or damage to personal property
g. Equipment problems, malfunctions or hazards; or mishaps due to faulty equipment

h. Deviations from provider policies, procedures, operating practices or professional standards of practice
i. Abuse of a child or adult
j. All significant adverse drug reactions
k. All significant medication errors
l. Documentation error

2. Actions to be taken in the event of an incident involving a client include:

a. The Division of Public Health Services' staff present shall contact the emergency response unit (911) if the client requires immediate medical care. If the client declines emergency medical treatment, he or she should be encouraged to report the accident/incident to his/her physician. The agency will notify the physician extender of any problems voiced or observed. The registered nurse or physician extender may need to assess the client's condition.

b. The Division of Public Health Services' staff member shall notify the Supervisor/Director of the accident/incident as soon as the client is stabilized and complete an Incident/Event Report within 24 hours.

C. Incidents Involving Staff

1. An accident or incident is any unusual or unexpected occurrence, while working, that leads, or could potentially lead to injury of a staff member or any incident where the staff's health, safety or welfare is adversely affected. These may include, but are not limited to:

a. falls
b. cuts
c. back pain while lifting or moving
d. automobile accidents
e. exposure to a communicable or reportable disease as defined in the policies on reportable infections
f. needle stick or other injury
g. dog bite
h. injury inflicted by a client

2. Actions to be taken in the event of an injury to a staff member include:

a. Any employee or contract staff involved in an accident or injury associated with employment must notify their

supervisor or the supervisor on call immediately and complete an Incident Report within 24 hours and the supervisor will notify the county safety risk manager as soon as possible.

b. Staff members who have an emergency should go to the closest Emergency Room immediately. UNC Health Rockingham Hospital is the preferred hospital. Staff can work on the proper paperwork and documentation at a later time. We do not want any delay in getting medical care. After medical care has been obtained for the employee, please call Medcor at 800-775-5866 to report the incident.

Report all injuries to Medcor (800-775-5866). They are available 24 hours/day, 7 days/week. Medcor will alert us that a report has been made and the safety risk manager will follow up with the supervisor as soon as possible.

c. If the staff member refuses to follow the approved protocol, then this is documented and the staff member is informed that potential Workman's Compensation coverage will not apply.

d. If the staff member is ordered not to work while recovering from the injury, a work release form indicating that the staff member may return to full duties must be provided to the appropriate supervisor.

e. Contract staff are to report any injury to their employer as soon as possible. Students should report any injury to their instructor as soon as possible.

f. Contractors/vendors are responsible for follow up of any work related injuries to contract staff, and for coordinating work return schedules with the Division of Public Health Services' supervisor of the program.

g. All serious illnesses or injuries of employees or contract staff that are determined to be work related are submitted appropriately.

D. <u>Incidence Reports</u>

1. Completed Incident Reports are submitted to the Administrative Supervisor of the Health Department for review.

These reports must be completed as thoroughly and accurately as possible. The following information is required at a minimum:

a. Name of the person involved in the accident/incident.
b. Date, time and place of the accident/incident.
c. As much detail about the accident/incident as possible

- what happened
- who was there, were there any witnesses
- what the client/employee was like before and just after the accident/incident
- was medical care received

d. Signature of the person completing the report.
e. Signature of Supervisor and/or Director of Nursing.

2. The Staff Development Coordinator is responsible for:

a. ensuring documentation of the incident
b. investigating the incident to determine the causal factors which may include:

- interviews with the person(s) involved
- review of agency policies, procedures, operating practices and professional standards of practice

c. preparing a written recommendation for actions to correct or prevent a similar occurrence. These recommendations may include, but are not limited to:

- revisions to provider policies, procedures and operating practices
- employee education, training and supervision
- employee disciplinary action - (follow-up provided by employee's supervisor)

d. preparing a quarterly summary of all incidents for the Quality Improvement Council.

3. Completed Incident Reports are filed in the agency's administrative files.

4. The QIC reviews a summary of all incidents quarterly to determine any trends and identify opportunities for organizational improvement.

5. A follow-up evaluation, appropriate to the action taken, is conducted of any action(s) initiated to prevent or correct the cause of incidents.

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ROCKINGHAM COUNTY DEPARTMENT
OF PUBLIC HEALTH
INCIDENT/EVENT REPORT

☐ Employee ☐ Client ☐ Other _____ Date & Time: _____

Name of Employee: _____ Employee Present: ☐ Yes ☐ No

Name of Client: _____ Client CR#: _____

Address: _____ Phone #: _____

Sex: ☐ Male ☐ Female Date of Birth: _____

Address/Location of Occurrence: _____

DESCRIPTION OF VARIANT EVENT/INJURY: (To be completed by person reporting event)
Description of property involved, how incident occurred, what the person was doing, result of incident, sequence of Events, other pertinent information.

_____

_____

_____

_____

_____

Identify who was responsible for individual while at the Health Department:

_____

_____

_____

_____

I. TYPE OF OCCURRENCE:

☐ Client fall
☐ Billing complaint
☐ Medical device injury
☐ Procedural injury
☐ Employee sprain/strain
☐ Employee animal contact
☐ Employee car accident
☐ Care plan not followed as ordered
☐ Medication Incident: wrong med _____
wrong client _____
wrong time _____
omission _____
incorrect dosage _____
☐ Documentation error
☐ Other client incident
☐ Medication reaction
☐ Failure to obtain consent
☐ Missing client property
☐ Damage to client property
☐ Employee occupational exposure

Condition before incident: ☐ Normal ☐ Disoriented ☐ Other _____

II. NOTIFICATION OF INDIVIDUALS/ACTION TAKEN:

Individual Notified	Name	Date Notified	Time Notified	Person Notifying
Physician/Physician Extender				
Supervisor				
Family (If Appl.)				
Director of Nursing				
Health Director				

III. OUTCOME/INTERVENTIONS IMPLEMENTED (Sent to Emergency Room, treated at the scene of the incident, no treatment required, client refused treatment)

_____

_____

What can be done to prevent future similar events (plan of care):

_____

_____

IV. INVESTIGATION OF EVENT: (TO BE COMPLETED BY SUPERVISOR)

Description of occurrence investigation, including dates:

_____

_____

_____

_____

Disposition:

☐ No harmful effects ☐ Now Resolved ☐ Continuing Treatment

☐ Client Satisfied ☐ Client Dissatisfied ☐ Property Repaired/Replaced

☐ Occurrence Unsubstantiated

Corrective Action Implemented? ☐ Yes Date: _____ No ☐

(Give Reason) _____

Description of Action: _____

_____

Outcome: _____

_____

V. FOLLOW-UP: (To be completed by Office Personnel)

Hours/Days of Work Missed:

_____

VI. FINAL DISPOSITION (To be completed by supervisor and/or director)

_____

_____

Employee _____ Date _____

Supervisor _____ Date _____

Director of Nursing _____ Date _____

Staff Development Coord. _____ Date _____

Health Director _____ Date _____

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: WORKPLACE BREASTFEEDING SUPPORT POLICY

DATE DEVELOPED: 1/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services will strive to allow breastfeeding staff members to pump breast while at work under the guidelines listed below.

II. PURPOSE:

To support employees in providing their child with the healthiest food nature has to offer, their own mother's breast milk.

III. GUIDELINES:

1. Breastfeeding employees shall be allowed a flexible schedule for nursing or pumping. The time allowed will not exceed the normal time allowed for lunch and breaks. For time above and beyond normal lunch and breaks, sick/annual leave will be used.

2. A confidential area will be provided where nursing women can pump breast milk to be stored for later use.

3. Mothers must provide their own refrigeration such as a cooler for storing breast milk.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: RECRUITMENT/HIRING

DATE DEVELOPED: 6/2000
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED 6/15; 6/18

I. POLICY:

It is the policy of the Division of Public Health Services to foster, maintain, and promote equal employment opportunity. The county shall select employees on the basis of applicant's qualifications and without regard to age, sex, race, color, creed, religion, political affiliation or national origin except where specific age, sex, or physical requirements constitute a bona fide occupational qualification necessary for job performance. Applicants with physical handicaps shall be given equal consideration with other applicants for positions in which their physical handicaps do not represent an unreasonable barrier to satisfactory performance of duties.

II. PURPOSE:

The Division of Public Health Services references the Rockingham County Personnel Policy Manual for recruitment of positions. All personnel responsible for recruitment and employment shall implement this personnel policy through procedures that will assure equal employment opportunity based on reasonable performance-related job requirements. The goal is to facilitate the optimum in staffing, in order to perform clinic and outreach activities efficiently and effectively.

III. GUIDELINES:

A. When positions are to be filled within the county, Department Heads shall notify the Personnel Officer concerning the number and classification of positions that are to be filled. The Personnel Officer or HR Department shall publicize these opportunities for employment including applicable salary ranges and employment qualifications. Information on job openings and hiring practices shall be provided to recruitment sources.

B. Employment advertisements shall contain assurances of equal employment opportunity and shall comply with federal and state statutes regarding discrimination in employment matters.

Recruitment for positions available in the Division of Public Health Services is carried out by the posting of a description of the position which includes salary or salary range dependent upon experience, a summary of the duties, minimum requirements and the county drug testing policy.

Position descriptions are posted for a period of one week to one month, or until such time as there are qualified applications filed.

Postings of the position are also available throughout the various county offices and applications are filed online at www.co.rockingham.nc.us.

C. All persons expressing interest in employment with the Division of Public Health Services shall be given the opportunity to file an application for employment when openings exist that meet job qualifications.

D. Upon applying, each applicant shall be informed of the availability of current job openings. Applications shall be kept in a reserve file for a period of two (2) years, in accordance with Equal Employment Opportunity Commission guideline. This is processed through the county's personnel department.

E. 1. Employees shall meet the employment standards established by the position classification plan and such other reasonable minimum standards of character, aptitude, ability to meet the public and physical condition as may be established by the Personnel Officer with the advice and recommendations of the Health Director. *Employees in positions subject to program standards and licensure requirements will be selected in accordance with all applicable federal and state laws and local policies.*

2. Qualifications shall be reviewed periodically to assure that requirements are fair and conform to the actual job performance requirements.

3. The Division of Public Health Services may employ an applicant in a trainee capacity who does not meet all minimum qualifications for a particular job if the deficiencies can be eliminated through orientation and on-the-job training.

F. 1. The interviews for positions may be conducted by the program supervisor/director, health director, and/or Rockingham County personnel staff member.

2. Certified, Registered, and/or Licensed personnel will have status verified prior to the interview. The Licensing Board is contacted for verification.

3. License must be kept current. Clinical/Dental Personnel without a current license or who do not possess a current renewal number will not be permitted to work.

4. An employed interpreter will be present during interviews for the interpreter position. During this interview the applicants' competencies are assessed for reading, speaking, writing, and interpreting a scenario in Spanish.

5. The Division of Public Health Services may request transcripts of applicants from all schools attended.

6. Environmental Health recruit for Registered R.S. (Registered Sanitarians/EH Specialist). If these applicants are not received, E.H. will accept a graduate from a 4-year college with 30 hours of sciences.

G. The Personnel Office shall make such investigations and conduct such examinations as deemed appropriate to assess fairly the aptitude, education and experience, knowledge and skills, character, physical fitness and other qualifications required for positions in the service of the county. All selection devices administered by the county or by persons or agencies for the county shall be valid measures of job performance.

H. It is the Division of Public Health Services' policy to create career opportunities for its employees when possible. Therefore, when a current employee applying for a vacant position possesses the best qualifications of all applicants, that applicant shall be appointed to that position.

However, if other applicants possess comparable qualifications and if the county could continue any historical discriminatory employment practices by automatically promoting or transferring the current employee without considering other applicants, the county must carefully consider the qualifications of other applicants in filling the position.

I. Before any commitment is made to an applicant, the Department Head shall forward the applicant's completed application form to the Rockingham County Personnel Officer with a recommendation concerning the classification of the position to be filled, the salary to be paid and the reasons for selecting the particular applicant over the others. After investigating the qualifications, satisfactory completion of drug screening, a criminal background review, and experience of the applicant, the Personnel Officer shall approve or reject the appointment and determine the classification and starting salary of the employee.

J. 1. An employee appointed or promoted to a permanent position shall serve a probationary period of six (6) months. An employee serving a probationary period following initial appointment may be dismissed at any time during the probationary period if found to be performing assigned duties unsatisfactorily. A post-probationary employee serving a probationary period following a promotion shall

be demoted according to Rockingham County Policy Manual if unable to perform assigned duties of the new job satisfactorily.

2. Before completion of the probationary period, all Department Heads shall indicate in writing to the Rockingham County Personnel Officer:

   a. That the employee's supervisor has discussed the new employee's progress (accomplishments, strengths, and weaknesses) with the new employee:
   b. Whether the new employee is performing satisfactory work;
   c. Whether the probationary period shall be extended;
   d. Whether the employee should be retained in the present position or should be released, transferred or demoted.
   e. No employee shall remain on probation for more than one (1) year.

K. Promotion:

   a. Candidates for promotion shall be chosen on the basis of their qualifications and their work records without regard to age, sex, race, color, creed, religion, political affiliation, national origin, or physical handicap. Performance appraisals and work records for all personnel who meet the minimum qualifications and apply for the position shall be carefully examined when openings for positions in higher classifications occur.
   b. Vacancies in positions shall be filled as far as practicable by the promotion of employees in the service of the county. However, consideration should be given to all qualified applicants who have been the objects of historical discrimination.
   c. If a current county employee is chosen for promotion, the supervisor shall forward the employee's name to the Rockingham County Personnel Officer with recommendations for classification and salary and reasons for selecting the employee over other applicants. After considering the supervisor's comments, and determining that the applicant is qualified, the Personnel Officer shall approve the appointment and determine the classification and starting pay.

L. Demotion:

   a. Any employee whose work in his/her present position is unsatisfactory or whose personal conduct is unsatisfactory may be demoted provided the employee shows promise of becoming a satisfactory employee in another position. Such a demotion shall be preceded by the warning procedures outlined in Article VII 8 of the Rockingham County Personnel Manual. Representative causes for demotion because of failure in work performance and failure in

personal conduct are listed in Article VII of the Rockingham County Personnel Manual.

b. If the demotion is for failure in performance of duties or failure in personal conduct, the employee shall be provided with written notice citing the recommended effective date and reasons for demotion and appeal rights available to the employee in Article VIII of the Rockingham County Personnel Manual.

c. An employee who wishes to accept a position with less complex duties and responsibilities may be demoted for reasons other than unsatisfactory performance of duties or failure in personal conduct.

M. Transfer:

a. If a vacancy occurs and an employee in another department is eligible for a transfer and is selected, the Department Head wishing to hire the employee shall request the transfer which shall be subject to the approval of the Rockingham County Personnel Officer. Any employee transferred without his having requested it may appeal the action in accordance with the grievance procedure outlined in Article VIII of Rockingham County Personnel Manual.

b. Any employee who has successfully completed a probationary period may be transferred to the same or similar class in a different department without serving another probationary period.

IV. WORK SCHEDULE:

A. Employees are expected to be at the workstation at 8:00 a.m. and to work assignment until 5:00 p.m. excluding lunch time. The supervisor must approve any digression from this policy. Some programs are approved flex time and the 8-5 schedule is adjusted.

B. Flex schedule will be approved by the Health Director/County Manager and will be approved only if it does not interfere with the normal operation of the area to which the employee is assigned.

C. All employees should call the Supervisor or Director prior to 7:00 a.m. on any day that the employee will not be reporting to work at the assigned time due to illness or emergency. Calls made after the workday has begun are sometimes not received in time to make the needed changes.

D. Call your Supervisor each day of your illness

E. Make sure your daily assignment is either transferred or deferred to another day, e.g. arrange to cancel appointments, have a co-worker trade with you, etc.

F. If you call in sick and think you may be able to come in to work later, please call if the situation changes. If you aren't coming in, your Supervisor needs to know.

G. The employee is expected to keep a tally of sick leave so as not to take leave un-accumulated. The paycheck stub contains fairly current information regarding sick and vacation leave. If questions arise, address them to Administration. Sick leave slips should be handed in to supervisor on the first day back to work.

H. If employee becomes ill during work hours a leave slip should be handed to supervisor prior to leaving building.

I. Upon employment the employee will be assigned to the program area for which he/she applied. During the interview process it will have been determined that the applicant is basically qualified for the position.

J. During the orientation period, while being observed for competencies in the assigned area, there will be opportunity provided for that employee to ask for additional training in order to feel that he/she is proficient in that particular job.

The preceptor/supervisor will be responsible for making available any training necessary for that employee to be able to perform those duties listed in the job description.

K. The employee has the right to refuse any assignment in which he/she feels inadequately trained. The employee does not have the right to refuse training for a skill in his/her assigned area.

All skills necessary for the job should be reviewed by the supervisor during the probationary period for any new employee.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PRESUMPTIVE ELIGIBILITY

DATE DEVELOPED: 3/08/98
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services' staff will assist clients applying for Presumptive Eligibility for Pregnancy Related Care.

II. PURPOSE:

To determine true eligibility of those residents/prenatals who are seeking assistance through County Funding.

III. GUIDELINES:

A. Presumptive Eligibility

1. All clients seeking county funding will read the disclaimer above the signature line on the Presumptive Eligibility for Pregnancy-Related Care form.

2. The disclaimer will be read again for the client by the employee taking the application. An emphasis should be placed on the last sentence for those who may not understand the consequences of false information given for purpose of obtaining Medicaid.

3. This explanation should by no means be threatening, however, only as a clarification of the language in the disclaimer.

4. Documentation of income is verified/collected from client and spouse only if applicable.

B. Address Verification

The employee taking the application should ask the client for the current address where they reside and should follow up by asking if the client receives mail at this address.

C. Applications

1. Each application should be enrolled into the Care Management for High Risk Pregnancies (CMHRP) Program (formerly Pregnancy

Care Management- PCM), the WIC program, and an appointment is scheduled with the doctor on the day that Presumptive Eligibility is established.

2. The client should be told to notify her caseworker if her address or telephone number changes.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DIVERSITY PLAN

DATE DEVELOPED: 1/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 8/08; 6/10; 6/14; 6/17; 6/18; 6/20; 6/22

I. POLICY:

The Division of Public Health Services strives to recruit and retain a diverse staff that mirrors the demographics of the community as best as possible in relation to gender and race/ethnicity.

II. PURPOSE:

The Diversity Plan will be updated on an annual basis in an effort to assess our current level of diversity as it compares to the community population.

III. GUIDELINES:

A. Demographics:

1. The demographics of the citizens of Rockingham County in relation to gender and race/ethnicity are as follows:

   a. Gender
      - Male 49.3%
      - Female 51.7%

   b. Race/Ethnicity
      - White 77.5%
      - Black or African American 19%
      - Hispanic/Latino 6.3%
      - Other race 2.1%

   (US Census data 2021)

2. The demographics of the Division of Public Health Services' staff in relation to gender and race/ethnicity are as follows:

   a. Gender
      - Male 4.28%
      - Female 94.28%

b. Race/Ethnicity
- White 64.3%
- Black or African American 30%
- Hispanic/Latino 5.7%

(Division of Public Health Services, Personnel, 2020)

B. Strength(s):

The department has increased our Hispanic/Latino employment over the previous years.

C. Needs:

A deficiency drawn from the comparison of demographics above suggests that the department recruit a larger male and Hispanic/Latino population in an effort to more closely mirror the demographics of the community.

D. Plan:

The Division of Public Health Services plans to promote public health careers more to a diverse population.

a. Presentations may be conducted within the local high schools for the health occupations classes in order to increase awareness of public health career path.

b. The health educator who is placed in the local high school student health centers will be asked to encourage students to pursue a career in the public health field.

c. Collaboration with surrounding colleges and universities to encourage more college students to pursue the public health career path.

26.2

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: RESEARCH POLICY: PROTECTION OF HUMAN SUBJECTS IN RESEARCH

DATE DEVELOPED: 1/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

The Division of Public Health Services does not routinely participate in clinical research projects. However, in the event this research project becomes necessary, the following will serve as guidelines.

II. PURPOSE:

To serve as a basis for future research projects as they are introduced and implemented.

III. GUIDELINES:

A. Background:

In July 1974 the United States Congress passed the National Research Act, which is intended to guarantee the protection of the rights of human subjects involved in biomedical and behavioral research. The Department of Health and Human Services maintains implementing regulations for the use of human subjects in research that is funded by the Federal Government. These guidelines specify the ethical principles that must be followed to insure that research subjects are treated humanely, that their dignity is maintained, and that their rights are preserved. The Federal guidelines and their revisions are published in the Code of Federal Regulations.

B. Policy:

Research done under the jurisdiction of The Division of Public Health Services shall not expose persons who participate as subjects or respondents to unreasonable risks to their health, general well being, or privacy.

Specifically, the Department is concerned that in all research, development, and related activities involving the use of human subjects:

1. The rights and welfare of the individuals be adequately protected;
2. The participation of subjects be based on freely given, informed consent;
3. The risks to the subject be so outweighed by the sum of the benefit to the subject or by the importance of the knowledge to be gained as to warrant a decision to allow the subject to accept these risks; and
4. The declining of participation at any time will in no way affect the eligibility of the subject to participate in other programs and receive other services provided by the Department.
5. The privacy of all subject will be protected and confidentiality of data maintained.

Therefore, all projects involving human subjects and conducted under the auspices of the Department are subject to review by the Rockingham County Board of Health and Human Services in order to ensure the protection of the rights and welfare of the individuals who participate as subjects.

All state and federal requirements will be followed regarding the rights of participants in local public health research programs. Any requests to access health department clients will have Institution Review Board approval obtained by the host research organization.

This policy applies to all research involving human subjects whether or not requests for outside funding are involved.

REFERENCES:

HHS Regulation at 45 CFR 46.102(f)
The Belmont Report

29.1
29.2

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TRANSLATION/INTERPRETER

DATE DEVELOPED: 11/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/19

I. POLICY:

To meet all the needs of individual clients and their families through written, verbal, or signed communications. The Division of Public Health Services strives to provide quality services to residents of Rockingham County to meet the requirements of the Americans with Disabilities Act and Title VI.

II. PURPOSE:

To make every effort to provide appropriate accommodations for clients who need a translator or interpreter.

III. GUIDELINES:

The client's rights are respected in a way that the staff consistently and clearly communicate with the client in a language or form understandable to him or her.

A. Children- Language used is simple and on a child's level, on-going evaluation is made of the environment and relationships between the parents, child and siblings.

B. Blind – Use special devices as necessary, large print books, etc. If client is identified as blind at the time the service is scheduled – the Division of Public Health Services' staff may encourage family or friend assistance when they present for services. The client allowing the assistance of someone other than the Division of Public Health Services' staff should sign a consent form. Refer to Lion's Club, Association of the Blind through DSS. The number to the Department of Social Services is 336-342-1394. The NC Division of Services for the Blind and Visually Impaired offers assistive devices.

C. Deaf and/or HOH – Clients that are hard of hearing or deaf will be given a piece of paper and pen to write notes for correspondence. "One to One" Communicator available, assist with obtaining a hearing aid device through the Service Center of Guilford County for Sign Language. Services may also be implemented through UMAR Arts Center of Reidsville at 336-342-3174. A request should be made as soon as possible prior to the client's appointment in order to give adequate time for the director to assign for

services. If possible, establish what type of interpreter services will be needed at the time the appointment is scheduled.

TELECOMMUNICATION DEVICE FOR THE DEAF:

Staff may need to have access to (TDD) or Teletypewriter (TTY) or amplified telephone receiver from the local telephone company to facilitate agency client communication as needed. Devices are available for sell or lease through BellSouth. Devices are for the hearing/visually impaired. The number to call to obtain information is 1-800-999-5737 or 1-800-982-2891. This information is also given to clients who are in need of these services.

Family members or friends may also be utilized during the time services are being provided. The client will be asked which type of translation/ interpretation is needed. The client will make the decision as to which service may be utilized.

Special information: The ADA requires that agencies provide "qualified interpreter services" for clients who are deaf or hard of hearing. By definition, a qualified sign interpreter effectively, accurately (expressively and receptively) communicates with the client and provider, using specialized vocabulary as necessary.

D. Trach – Provide paper and pencil, also pictures may be used.

E. Dementia – To preserve the dignity of the client, instructions involving their care is verbalized to the caregiver with the client being present in appropriate situations.

F. Foreign Language – The Division of Public Health Services has translators on staff to assist during clinic services. Written and verbal information may be provided in Spanish according to material needed. If the information is not available in Spanish, the translator will read and inform the client of the material content to assure their level of understanding.

There is a posted notice at the reception desk that identifies the different languages that may be addressed by the client. The client points to the language of their choice in order to identify their native language.

The Language Line can be utilized if needed by calling 1-800-514-9237.

G. Staff will inform the client that translator services are available on site. If the Health Department Staff translation services are utilized, the first and last name of the translator needs to be identified within the documentation on the client's record. Some client's may choose the interpretive assistance from a family member or friend. If so, staff should inform the client that

confidential information may be revealed. Then allow the client to choose their translator source. Minor children (under 18 years of age) should not be used as the interpreter unless it is an emergency service or extenuating circumstance where the client's services are needed right away and no one else is available. If the client chooses to continue with the family member as the interpreter, this should be documented within the client's clinical record and documented that the Division of Public Health Services' Interpreter services were available and offered. The program area should have the "Declination of Interpreter Services Form" completed and signed at each visit in which interpreter services are declined.

H. The staff may assist the client to obtain special devices or aids to facilitate communication as needed.

I. Cultural considerations for all clients shall be respected and observed. Where such considerations impede the provisions of prescribed health care or treatment, personnel shall notify the supervisor, Director of Nursing or Health Director in an effort to accommodate the client.

J. When staff interpreter services are rendered, the name of the interpreter may be on documentation, as needed.

K. The Division of Public Health Services will use informational signs in Spanish to better assist clients through the flow of the Health Department. These signs are presented in Spanish because of our increasing Hispanic population.

L. Ongoing efforts are made to increase cultural competency for optimal care by recruiting bilingual staff, offering workshops and providing county sponsored Spanish/Language classes on work time for interpreter staff.

M. Staff are approved to access the Spanish interpreter line as it is available.

N. Staff are encouraged to make available linguistically appropriate printed documents to clients whenever possible. Client education materials are available in Spanish (because Spanish is our largest foreign language required) throughout most programs.

O. Staff is to ascertain that the client is "informed" when signing consents and/or releases of information. Whenever possible the client signs consents and/or releases of information that have been translated into their primary language. Whenever this is not possible, the interpreter should sign as a witness and indicated that the client received verbal (or signed) instructions prior to signing the agreement/release.

P. No certification is required to interpret a foreign language. It is therefore important that the interpreter be able to communicate adequately and not change the meaning of either party's information.

Q. It is inappropriate to use county interpreters to complete the actual clinical record. This would include the history, flow sheet, or any documentation pertaining to the services that are rendered or interview conducted while the client is being seen for services throughout the health department.

R. The NC office of Minority Health has issued further guidance in how to effectively utilize interpreter services. The following applies:

1. The provider must rely on the third party as the interpreter to convey the information, thoughts and opinions.
2. The interpreter must have a thorough understanding of both the target language and the source language. In addition, the interpreter must be familiar with the culture and traditions of both.
3. The interpreter should speak in first person and avoid saying "he" or "she" says. This allows the provider and client to speak directly to each other.
4. Consecutive Interpretation- allows one to speak in short sentences and pause while the interpreter repeats what is said.
5. The provider should look directly at the client and not the interpreter when speaking.
6. It is not appropriate to delegate the responsibility of interviewing to the interpreter.
7. It is not appropriate to allow the interpreter to document responses on the chart with the exception of a telephone note.
8. The role of the interpreter is to translate every word said in the room and not to assume that because they can interpret that they can complete the medical forms.
9. The interpreter may sign their name to necessary documentation after the provider's name to indicate who the interpreter was that assisted with the interview.

S. The health department does not require a client to provide his or her own interpreter.

T. When a client presents to the health department and is accompanied by an English-speaking friend or family member, it is best not to use them as an interpreter. Their assistance is not entirely prohibited but is restricted to very limited circumstances.

Friends and family members may be used as interpreters only if all of the following conditions are met:

1. The health department must inform the client in a language the client can understand that the department will provide an interpreter at no charge to the client.
2. After being informed the client must ASK to use the friend or family member as an interpreter.
3. The health department must determine that use of the friend or family member as an interpreter will not compromise either the effectiveness or confidentiality of the service.

IV. ACCESSING INTERPRETER SERVICES:

In accordance with the Division of Public Health Services' desire to provide quality services to the residents of Rockingham County and to meet the requirements of the Americans with Disabilities Act and Title VI, the Division of Public Health Services makes every effort to provide linguistically and culturally appropriate information and services to clients.

A. Procedure for serving clients in the clinic who speak no English

1. When a non-English-speaking-only client walks into the clinic:

   a. Refer the client to the "Interpretation Services Available" sheet to identify the language. The client will point to the language they speak.
   b. Establish communication with the client:

      - If the identified language is Spanish, call an interpreter to the front.
      - If the identified language is Spanish and an interpreter is not available, utilize the phone line service.
      - If the identified language is NOT Spanish and the client cannot read, call the Language Line to assist you to determine the language.

   c. Determine the client's need:

      - If a bilingual staff member or interpreter is available, make initial contact on-site.
      - Use the Language Line to make the appropriate appointment or route them to the appropriate clinic.

2. When a Spanish-speaking-only client calls the clinic:

   a. Check to see if a bilingual staff member or interpreter is on-site and forward the call to that person.
   b. If it is not an emergency and there is no bilingual staff or interpreter available on-site, transfer them to the Spanish Voice Mail at x8206.

c. If it is an emergency and there is no bilingual staff or interpreter available, use the language line.

B. Procedure for Answering the Division of Public Health Services' Spanish Voice Mail:

1. The Voice Mail Box will be checked at least twice daily during all days of normal operation by the assigned staff.
2. The message will be changed as needed for holidays by the assigned staff person.
3. When the Voice Mail is checked, the assigned staff person will:

   a. Call the client back to determine needs.
      - If the client is calling to schedule an appointment, the interpreter will do so over the phone.
   b. Record the messages received in the EHR under telephone note.

C. Procedure for Ensuring Standards of Practice During Interpretation Services

1. Accuracy – to enable other parties to know precisely what each speaker has said.

   a. The interpreter renders all messages accurately and completely, without adding, omitting, or substituting.
   b. The interpreter replicates the register, style, and tone of the speaker.
   c. The interpreter advises parties that everything said will be interpreted.
   d. The interpreter manages the flow of communication.
   e. The interpreter corrects errors in interpretation.
   f. The interpreter maintains transparency.

2. Confidentiality – to honor the private and personal nature of the health care interaction and maintain trust among all parties.

   a. The interpreter maintains confidentiality and does not disclose information outside the treating team, except with the client's consent or if required by law.
   b. The interpreter protects written client information in his/her possession.

3. Impartiality – to eliminate the effect of interpreter bias or preference.

   a. The interpreter does not allow personal judgments or cultural values to influence objectivity.

b. The interpreter discloses potential conflicts of interest, withdrawing from assignments if necessary.

4. Respect – to acknowledge the inherent dignity of all parties in the interpreted encounter.

   a. The interpreter uses professional, culturally appropriate ways of showing respect.
   b. The interpreter promotes communication among all parties in the encounter.
   c. The interpreter promotes client autonomy.

5. Cultural Awareness – to facilitate communication across cultural differences.

   a. The interpreter strives to understand the cultures associated with the language he or she interprets, including biomedical culture.
   b. The interpreter alerts all parties to any significant cultural misunderstanding that arises.

6. Role Boundaries – to clarify the scope and limits of the interpreting role, in order to avoid conflicts of interest.

   a. The interpreter limits personal involvement with all parties during the interpreting assignment.
   b. The interpreter limits his or her professional activity to interpreting within an encounter.
   c. The interpreter with an additional role adheres to all interpreting standards of practice while interpreting.

7. Professionalism – to uphold the publics' trust in the interpreting profession.

   a. The interpreter is honest and ethical in all business practices.
   b. The interpreter is prepared for all assignments.
   c. The interpreter discloses skill limitations with respect to particular assignments.
   d. The interpreter avoids sight translation, especially of complex or critical documents, if he or she lacks sight translation skills.
   e. The interpreter is accountable for professional performance.
   f. The interpreter advocates for working conditions that support quality interpreting.
   g. The interpreter shows respect for professionals with whom he or she works.
   h. The interpreter acts in a manner befitting the dignity of the profession and appropriate to the setting.

8. Professional Development – to attain the highest possible level of competence and service.

    a. The interpreter continues to develop language and cultural knowledge and interpreting skills.
    b. The interpreter seeks feedback to improve his or her performance.
    c. The interpreter supports the professional development of fellow interpreters.
    d. The interpreter participates in organizations and activities that contribute to the development of the profession.

9. Advocacy – to prevent harm to parties that the interpreter serves.

    a. The interpreter may speak out to protect an individual from serious harm.
    b. The interpreter may advocate on behalf of a party or group to correct mistreatment of abuse.

Reference: National Council on Interpreting in Health Care – September 2005

9.6

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EQUIPMENT REPLACEMENT PLAN

DATE DEVELOPED: 1/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15

I. POLICY:

The Division of Public Health Services will follow the following guidelines for replacing equipment within the programs.

II. PURPOSE:

To establish and implement a consistent and workable plan for replacing equipment and to maintain a cost effective plan.

III. GUIDELINES:

1. As a component of the annual budget preparation process, program supervisors are to access the current equipment within their program or unit.

2. Equipment replacement will be assessed based on maintenance issues, availability of replacement parts, age, use, condition, safety, and conformance with existing standards.

3. A hardware assessment is completed by the IT Business Analyst each year for review of equipment needs and to meet accreditation standards. Requests will be discussed with the Health Director and/or county IT representatives based on needs and justification.

4. Items identified in need of replacement should be included with the Health Department's budget requests accompanied by a written justification for the equipment replacement including the disposition of the equipment item to be taken out of service.

5. All county-owned vehicles will be assessed for replacement based on the county's vehicle replacement policy. This policy is based on the age of the vehicle, the vehicle mileage, same repair three or more times in a one year period, known upcoming major repairs, vehicle meeting department's current needs and the annual maintenance cost. Vehicles to be considered for replacement are based on to the point system criteria of the Rockingham County Fleet Management Program Policy.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: IDENTITY THEFT RED FLAG

DATE DEVELOPED: 3/09
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Rockingham County Board of Health adopts by reference the Identity Theft Red Flag Policy, Effective Date – November 1, 2008 and future revisions adopted by the Rockingham County Board of Commissioners.

II. PURPOSE:

In comply with the Identity Theft Red Flag Policy, special considerations are to be observed by the Division of Public Health Services' staff:

1. Full social security numbers shall only be obtained when required for patient identification purposes such as the submission of medical specimens for laboratory analysis or where required by Federal or State law or regulation.

2. Individually identifiable information about clients in clinical programs is subject to both the HIPAA medical privacy rule and State confidentiality laws. In addition, some programs may be subject to other confidentiality requirements. Responses to red flags should not involve disclosures of such information unless the disclosures are permitted under all applicable confidentiality laws.

3. As recipients of Federal financial assistance, the Division of Public Health Services must comply with Title VI of the Federal Civil Rights Act. The Department prohibits discrimination on the basis of race, color, or national origin. In complying with the Identity Theft Red Flag Policy, no Department policies or procedures shall have the effect of denying or impeding services to any of these groups, even if the policies or procedures are not intended to treat the different groups differently.

4. Responses to red flags should not be structured in a way that denies services to individuals who are otherwise eligible for them, or that undermines the Department's ability to protect the public health.

Red flags identified by the Division of Public Health Services' employees should be referred to their supervisor for assistance in following the appropriate steps to prevent and mitigate identity theft while complying with the special considerations required of local health departments.

/di

Clerk to the Board

Memo

To: Department Heads

From: Pam McLain, Clerk to the Board

CC: Tom Robinson, County Manager

Date: 10/8/2008

Re: Adoption of Identity Theft Prevention Policy

The Rockingham County Board of Commissioners, at their regular meeting of October 6, 2008, adopted the attached Identity "Theft Prevention Policy" for Rockingham County, effective November 1, 2008.

Please incorporate this document into your *Policy and Procedures Notebook* for reference.

	Rockingham County Policies & Procedures Identity Theft Red Flag Policy		
Department: Finance		**Policy #**	**Pages:**
Prepared By: Legal Department		**Effective Date: November 1, 2008**	
Approved By: Board of County Commissioners		**Revised:** _____	
Authority Source: **Signature:**			

I. PROGRAM ADOPTION

Rockingham County developed this Identity Theft Prevention Program ("Program") pursuant to the Federal Trade Commission's Red Flags Rule ("Rule"), which implements Section 114 of the Fair and Accurate Credit Transactions Act of 2003. 16 C. F. R. § 681.2. This Program was developed with oversight and approval of the Board of County Commissioners. After consideration of the size and complexity of the County's utility operations and other creditor account systems, and the nature and scope of the County's creditor activities, the Board of County Commissioners determined that this Program was appropriate for Rockingham County, and therefore approved this Program on October 6, 2008.

II. PROGRAM PURPOSE AND DEFINITIONS

A. Fulfilling requirements of the Red Flags Rule

Under the Red Flag Rule, every financial institution and creditor is required to establish an "Identity Theft Prevention Program" tailored to its size, complexity and the nature of its operation. Each program must contain reasonable policies and procedures to:

1. Identify relevant Red Flags for new and existing covered accounts and incorporate those Red Flags into the Program;
2. Detect Red Flags that have been incorporated into the Program;
3. Respond appropriately to any Red Flags that are detected to prevent and mitigate Identity Theft; and
4. Ensure the Program is updated periodically, to reflect changes in risks to customers or to the safety and soundness of the creditor from Identity Theft.

B. Red Flags Rule definitions used in this Program

The Red Flags Rule defines "Identity Theft" as "fraud committed using the identifying information of another person" and a "Red Flag" as a pattern, practice, or specific activity that indicates the possible existence of Identity Theft.

According to the Rule, a local government utility is a creditor subject to the Rule requirements. The Rule defines creditors "to include finance companies, automobile dealers, mortgage brokers, utility companies, and telecommunications companies. Where non-profit and government entities defer payment for goods or services, they, too, are to be considered creditors."

All of the Rockingham County utility accounts that are individual utility service accounts held by customers of the utility whether residential, commercial or industrial are covered by the Rule. However, accounts other than utility accounts may be covered as well. Under the Rule, a "covered account" is:

1. Any account the County offers or maintains primarily for personal, family or household purposes, that involves multiple payments or transactions; and
2. Any other account the County offers or maintains for which there is a reasonably foreseeable risk to customers or to the safety and soundness of the County from Identity Theft.

"Identifying information" is defined under the Rule as "any name or number that may be used, alone or in conjunction with any other information, to identify a specific person," including: name, address, telephone number, social security number, date of birth, government issued driver's license or identification number, alien registration number, government passport number, employer or taxpayer identification number, unique electronic identification number, computer's Internet Protocol address, or routing code.

III. IDENTIFICATION OF RED FLAGS.

In order to identify relevant Red Flags, the County considers the types of accounts that it offers and maintains, the methods it provides to open its accounts, the methods it provides to access its accounts, and its previous experiences with Identity Theft. The County identifies the following red flags, in each of the listed categories:

A. Notifications and Warnings From Credit Reporting Agencies

Red Flags

1) Report of fraud accompanying a credit report;
2) Notice or report from a credit agency of a credit freeze on a customer or applicant;
3) Notice or report from a credit agency of an active duty alert for an applicant; and
4) Indication from a credit report of activity that is inconsistent with a customer's usual pattern or activity.

B. Suspicious Documents

Red Flags

1. Identification document or card that appears to be forged, altered or inauthentic;
2. Identification document or card on which a person's photograph or physical description is not consistent with the person presenting the document;
3. Other document with information that is not consistent with existing customer information (such as if a person's signature on a check appears forged); and
4. Application for service that appears to have been altered or forged.

C. Suspicious Personal Identifying Information

Red Flags

1. Identifying information presented that is inconsistent with other information the customer provides (example: inconsistent birth dates);

2. Identifying information presented that is inconsistent with other sources of information (for instance, an address not matching an address on a credit report);
3. Identifying information presented that is the same as information shown on other applications that were found to be fraudulent;
4. Identifying information presented that is consistent with fraudulent activity (such as an invalid phone number or fictitious billing address);
5. Social security number presented that is the same as one given by another customer;
6. An address or phone number presented that is the same as that of another person;
7. A person fails to provide complete personal identifying information on an application when reminded to do so (however, by law social security numbers must not be required); and
8. A person's identifying information is not consistent with the information that is on file for the customer.

D. Suspicious Account Activity or Unusual Use of Account

Red Flags

1. Change of address for an account followed by a request to change the account holder's name;
2. Payments stop on an otherwise consistently up-to-date account;
3. Account used in a way that is not consistent with prior use (example: very high activity);
4. Mail sent to the account holder is repeatedly returned as undeliverable;
5. Notice to the County that a customer is not receiving mail sent by the County;
6. Notice to the County that an account has unauthorized activity;
7. Breach in the County's computer system security; and
8. Unauthorized access to or use of customer account information.

E. Alerts from Others

Red Flag

1. Notice to the County from a customer, identity theft victim, law enforcement or other person that it has opened or is maintaining a fraudulent account for a person engaged in Identity Theft.

IV. DETECTING RED FLAGS.

A. New Accounts

In order to detect any of the Red Flags identified above associated with the opening of a **new account**, County personnel will take the following steps to obtain and verify the identity of the person opening the account:

Detect

1. Require certain identifying information such as name, date of birth, residential or business address, principal place of business for an entity, driver's license or other identification;
2. Verify the customer's identity (for instance, review a driver's license or other identification card);
3. Review documentation showing the existence of a business entity; and
4. Independently contact the customer.

B. Existing Accounts

In order to detect any of the Red Flags identified above for an **existing account**, County personnel will take the following steps to monitor transactions with an account:

Detect

1. Verify the identification of customers if they request information (in person, via telephone, via facsimile, via email);
2. Verify the validity of requests to change billing addresses; and
3. Verify changes in banking information given for billing and payment purposes.

V. PREVENTING AND MITIGATING IDENTITY THEFT

In the event County personnel detect any identified Red Flags, such personnel shall take one or more of the following steps, depending on the degree of risk posed by the Red Flag:

Prevent and Mitigate

1. Continue to monitor an account for evidence of Identity Theft;
2. Contact the customer;
3. Change any passwords or other security devices that permit access to accounts;
4. Not open a new account;
5. Close an existing account;
6. Reopen an account with a new number;
7. Notify the Program Administrator for determination of the appropriate step(s) to take;
8. Notify law enforcement; or
9. Determine that no response is warranted under the particular circumstances.

Protect customer identifying information

In order to further prevent the likelihood of identity theft occurring with respect to County accounts, the County will take the following steps with respect to its internal operating procedures to protect customer identifying information:

1. Ensure that its website is secure or provide clear notice that the website is not secure;
2. Ensure complete and secure destruction of paper documents and computer files containing customer information;
3. Ensure that office computers are password protected and that computer screens lock after a set period of time;
4. Keep offices clear of papers containing customer information;
5. Request only the last 4 digits of social security numbers (if any);
6. Ensure computer virus protection is up to date; and
7. Require and keep only the kinds of customer information as is necessary for the purpose of the account.

VI. PROGRAM UPDATES

This Program will be periodically reviewed and updated to reflect changes in risks to customers and the soundness of the County from Identity Theft. At least annually, the Program Administrator will consider the County's experiences with Identity Theft situation, changes in

Identity Theft methods, changes in Identity Theft detection and prevention methods, changes in types of accounts the County maintains and changes in the County's business arrangements with other entities. After considering these factors, the Program Administrator will determine whether changes to the Program, including the listing of Red Flags, are warranted. If warranted, the Program Administrator will update the Program or present the Board of County Commissioners with his or her recommended changes and the Board of County Commissioners will make a determination of whether to accept, modify or reject those changes to the Program.

VII. PROGRAM ADMINISTRATION.

A. Oversight

Responsibility for developing, implementing and updating this Program lies with a Program Administrator appointed by the County Manager. The Program Administrator will be responsible for the Program administration, for ensuring appropriate training of County staff on the Program, for reviewing any staff reports regarding the detection of Red Flags and the steps for preventing and mitigating Identity Theft, determining which steps of prevention and mitigation should be taken in particular circumstances and considering periodic changes to the Program.

B. Staff Training and Reports

County staff responsible for implementing the Program shall be trained either by or under the direction of the Program Administrator in the detection of Red Flags, and the responsive steps to be taken when a Red Flag is detected.

C. Service Provider Arrangements

In the event the County engages a service provider to perform an activity in connection with one or more accounts, the County will take the following steps to ensure the service provider performs its activity in accordance with reasonable policies and procedures designed to detect, prevent, and mitigate the risk of Identity Theft.

1. Require, by contract, that service providers have such policies and procedures in place; and
2. Require, by contract, that service providers review the County's Program and report any Red Flags to the Program Administrator.

D. Specific Program Elements and Confidentiality

For the effectiveness of Identity Theft prevention Programs, the Red Flag Rule envisions a degree of confidentiality regarding the County's specific practices relating to Identity Theft detection, prevention and mitigation. Therefore, under this Program, knowledge of such specific practices is to be limited to the Program Administrator and those employees who need to know them for purposes of preventing Identity Theft. Because this Program is to be adopted by a public body and thus publicly available, it would be counterproductive to list these specific practices here. Therefore, only the Program's general red flag detection, implementation and prevention practices are listed in this document.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: STORAGE AND DISPENSING OF PRESCRIPTION PADS

DATE DEVELOPED: 5/09
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/12

I. POLICY:

The Division of Public Health Services will ensure prescription pads are received, stored, dispensed, and destroyed securely within the agency.

II. PURPOSE:

To maintain accountability and security of all prescription pads within the Division of Public Health Services.

III. GUIDELINES:

A. New prescription pads received will be stored in a secure, locked area in the pharmacy of the Division of Public Health Services.

B. When new prescription pads arrive, the pharmacist will count the number of pads and keep a log in the pharmacy to maintain the number of prescription pads available.

C. Providers or supervisors will sign, date, and document the number of prescription pads removed from the pharmacy. One prescription pad per program should be removed from the pharmacy at a time.

D. Providers will keep their prescription pads in their lab jackets while serving clients. When the provider goes to lunch or after office hours, prescription pads will be stored in the provider's locked file cabinet.

E. When old prescription pads are discarded, the pharmacist or a supervisor will destroy the old pads by shredding. The pharmacist will record the number destroyed, date, and by whom and keep on file.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: AUDIT OF PETTY CASH BOXES

DATE DEVELOPED: 7/09
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/21

I. POLICY:

The Division of Public Health Services maintains (10) Petty Cash Boxes that are to be audited at least two times per year. The cash boxes are located as follows: three in Administration, five in the clinical registration and checkout area, Dental Clinic, and Pharmacy. The cash boxes were established for the express purpose of making change from cash payments for clinical, dental, environmental health services, and pharmacy prescription programs. Cash boxes are not to be used as a method to bypass the County's Accounts Payable, Travel Reimbursement, Purchasing, or Procurement Card systems. The cash box in the Accounting Assistant's office was established for small incidental expenditures and shall be replenished periodically or when funds are low as determined by the Accounting Assistant.

II. PURPOSE:

Internal discretionary audits of cash boxes are to be conducted randomly for the department's files. These audits are to be done at least 2 times per fiscal year, with at least a six month interval between audits. The results will be maintained in the Accounting Specialist's and Accounting Assistant's office. All cash boxes/bags are in locked files.

Random audits may be requested by the Finance Department at anytime. The results will be forwarded to Finance and a copy will be maintained in the Accounting Specialist's and Accounting Assistant's offices.

Year-end audits will be conducted each year by the end of July. The results will be forwarded to Finance by the Accounting Assistant and a copy will be maintained in the Accounting Specialist's office.

III. GUIDELINES FOR YEAR-END OR FINANCE DEPARTMENT RANDOM AUDITS:

Procedures for performing audits will be as follows:

Petty cash boxes – located in all locations.

1. Count cash in box
2. Total expenditures paid and documented in box
3. The total of (1) plus (2) should equal the pre-set amount for that individual cash box.

Using results of each item 1-6, fill in form designated for audit of cash boxes in the Health Department per instructions noted in headings of form (see attached example of form). [If any discrepancy exists it must be thoroughly investigated, documented, and brought to the attention of the Accounting Specialist. Documentation should be completed by the custodian of the cash box, signed by custodian and immediate supervisor, and be submitted to the Accounting Specialist promptly. Attach documentation to completed audit form.]

Print out completed form, sign and date. Each form should be consistent with the name of the cash box**.** Give to the Accounting Specialist to sign and date and forward to County Finance.

IV. GUIDELINES FOR INTERNAL DISCRETIONARY AUDITS:

1. Write the number of bills by correct denomination under "Cash on Hand" label. Multiply this number by bill denomination and write in total.
2. Write the number of coins by correct denomination under "Cash on Hand" label. Multiple this number by coin denomination and write in total.
3. Write the vendor name and receipt amount under "Receipts" label. Calculate receipt amounts and write the total by "Total Receipts".
4. Count the number of checks and/or money orders and write this under the label "Checks" and the subheading "Count of Checks".
5. Add the amount of checks up and write this total under subheading "Total Checks".
6. Under "Reconciliation of Petty Cash/Cash Box" heading, write in the total amounts of cash on hand, checks, receipts and amount of fund. Add the first three numbers together and subtract out the fourth number (amount of fund). Write the result beside the "=" (variance) mark. If this number is equal to 0 the cash box balanced.

   If any discrepancy exists it must be thoroughly investigated, documented, and brought to the attention of the Accounting Specialist. Documentation should be completed by the custodian of the cash box, signed by custodian and immediate supervisor, and be submitted to the Accounting Specialist promptly. Attach documentation to completed audit form.

7. Explain any discrepancies and findings in the notes section.
8. Cash box custodian and auditing staff are to both sign and date this form.

Rev/di

Rockingham County DHHS
Division of Public Health

CASH BOX AUDIT FORM

Audit Date ____________________ Cash Box Location Administration (Other)

Amount of Fund ____________________

CASH ON HAND			
	BILLS		TOTAL
CURRENCY			
	COINS		TOTAL
TOTAL CASH ON HAND			

RECEIPTS	
VENDOR	AMOUNT
TOTAL RECEIPTS	

CHECKS		
CHECKS/ MONEY ORDERS	COUNT OF CHECKS	TOTAL CHECKS

RECONCILIATION OF PETTY CASH/CASH BOX		
CASH ON HAND	+	
CHECKS	+	
RECEIPTS	+	
AMOUNT OF FUND	-	
VARIANCE	=	

NOTES	

Signed by: ______________________________ **Date:** __________

Cash Box Custodian

Audited by: ______________________________ **Date:** __________

Name/Title

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ELECTRONIC HEALTH RECORDS

DATE DEVELOPED: 12/14
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED 6/16; 6/17

I. POLICY:

Employees will be provided training on and access to the Electronic Health Record (EHR). Staff shall follow state program guidelines, accepted medical/dental/ nursing practice, rules and legal guidelines while documenting in the patient's electronic medical record. The current clinic health system is Patagonia; the current dental clinic system is Dentrix Enterprise.

II. PURPOSE:

To establish and outline processes and procedures for permitting clinical and management support staff access to the Electronic Health Records of patients in order to enhance the continuum of health care.

III. PROCEDURE:

A. Employees using the EHR will be given a unique username and password. An administrator will provide new employees their username and password.

B. Passwords are not to be shared among other employees.

C. Employees will be trained on the EHR system. Training will cover basic functions of the system as well as program specific functions and will be based on individual employee's computer literacy level. Nursing supervisors and the Director of Nursing are responsible for oversight of training and evaluation of competency in the clinic health system. Oversight of training and evaluation of competency for the dental clinic system is the responsibility of the Dental Clinic Supervisor.

D. All providers will review the history portion of the patient record every visit prior to examination. The provider's signature at the close of the patient visit/encounter indicates that they have reviewed and are in agreement with the documentation in the note. All providers/nurse practitioners will sign their own work within the EHR. Co-signing will be utilized when applicable.

E. All documentation will be completed within two (2) business days.

F. For Clinic Health System Only - Vaccine administration: vaccines will be reviewed/documented in the North Carolina Immunization Registry (NCIR) and documented in the EHR.

G. If a documentation error has occurred and the encounter note has been signed, saved and locked; staff should contact their supervisor who will contact one of the administrators. After reviewing the encounter note, it will be determined to either delete the entire encounter note or have the employee add an explanation or addendum to the encounter note explaining the error.

IV. DOCUMENTATION:

A. Practice management consists of patient registration including patient/provider appointments/scheduling, patient demographics, family income, sliding fee scales and declaration of income, etc.

B. Electronic billing consists of collecting patient payments, electronic insurance eligibility, sending electronic claims to payers, receiving electronic remittance advice, patient statements, and financial reports.

C. The EHR consists of electronically capturing patient information by clinicians (including public health nurses and mid-level providers and others as deemed necessary).

V. LEVEL OF ACCESS:

Generally employees will be granted access to the EHR based on individual job duty and titles. However, level of access may change or be augmented based on the needs of the agency.

A. Program Administrators will have access to Patagonia in its entirety including EHR, billing, patient demographics, income information and clinic schedules.

B. Clinical staff will have access to EHR, clinic schedules and patient demographics.

C. Management Support Staff will have access to the EHR**,** clinic schedules and patient demographics.

D. Women, Infants and Children (WIC), Care Management for At Risk Children (CMARC), and Care Management for High Risk Pregnancies (CMHRP) may have access to patient demographics and clinic schedules only.

VI. POWER OUTAGES AND CONNECTIVITY PROBLEMS:

In the event of a power outage or system connectivity problem, all visits are to be documented using a paper charting system. When system is available all paper charting must be entered into the EHR system as soon as feasible (no later than 48 hours).

VII. TERMINATION OF EMPLOYEE ACCESS:

Upon termination of employment and/or transfer to another department, the user will be classified as inactive in the system by the Program Administrator and will no longer have access to the system.

VIII. SYSTEM BACK-UP AND AVAILABILITY:

The system is web based, accessible via internet with web browser and available for users 24/7. All functions of the EHR and billing system are operational continuously. The system may not be available during system updates.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PATIENT PORTAL POLICY AND PROCEDURES

DATE DEVELOPED: 6/15
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18

I. POLICY:

Guidelines and rules for Patient Portal Access provided through Patagonia Electronic Health Record System for patients 18 years of age and older.

II. PURPOSE:

To establish and outline processes and procedures for providing a patient portal as a courtesy to our patients 18 years of age and older. If inappropriate or negligent usage of patient portal occurs, counsel patient on appropriate use of portal. Inappropriate usage may include but is not limited to:

- Do not use portal communication if there is an emergency, please dial 911 or go to the nearest Emergency Room.
- No Internet based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules an appointment and has been seen by a provider.
- Do not request medication refills through patient portal; please contact your pharmacy.

III. PROCEDURES:

A. Initial Email Address Entry

Management Support Staff will obtain the patient's email address if the patient is interested in participating in the patient portal. The patient's email address must be entered using all lower case letters into the Patient Demographics email field. Staff must click *Save Demographics* button. Then click the *Activate Patient Portal* button. This will send the welcome email to the patient's email address.

1. Activation - Email addresses will only be entered into the Email Field when the patient is present in the clinic.
2. An orange flag will be entered in the system to indicate if a client has been offered Patient Portal.
3. Staff will provide the following information to the patient during enrollment process:

    - An attempt will be made to send a "welcome message" to your email; it will include a link to the Patient Portal Policy. *If the

patient does not receive the email within 3 business days; they should call 336-342-8141.

- Login/enrollment to the patient portal indicates the patient agrees with the Patient Portal Policy.
- All electronic communications must be through Patient Portal Messaging and not through personal email accounts.
- Typically a response to messages received through patient portal will occur within 3 business days after receipt of the original message.
- Some information, including lab work, may not be available within the Patient Portal System.

B. Portal Password Reset

For patient's requesting a password reset via telephone, management support will educate the patient regarding usage of the *Password Reset* button on the portal login screen. The patient will receive an email containing the reset password to the email address in the system. **THE STAFF ARE <u>NOT</u> TO CHANGE AN EMAIL ADDRESS OVER THE TELEPHONE**.

C. Portal Email Address Change

Staff may change a patient's email address **<u>ONLY</u>** if the patient presents in clinic and has an appropriate form of identification (driver's license or state/federal issued photo identification card).

IV. <u>PATAGONIA MESSAGING</u>:

A. All staff with a Patagonia user account must login and check the message center each business day they are scheduled to work.

B. Staff should respond to Patagonia Portal Messages received from clients or staff within one business day; this may include contacting the patient or another staff member to provide the patient with needed information.

C. Two generic accounts will be available for messaging regarding appointments and billing. These accounts are for patient use only. Staff assigned to monitor these accounts must login and check each business day they are scheduled to work. Response to these messages will follow protocol as noted in paragraph IV - B above.

D. The practice administrator will monitor messages in the event of an absence of staff members. The practice administrator may assign the request to a designee for follow-up of messages sent to staff that are not available.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ELECTRONIC RECORDS AND IMAGING, SCANNING AND DESTRUCTION OF RECORDS

DATE DEVELOPED: 8/15
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 3/24; 6/24
REVISED: 6/17; 3/24

I. PURPOSE:

The records covered by this policy are in the custody of Rockingham County Department of Health and Human Services Division of Public Health and are maintained for the benefit of agency use in delivering services and in documenting agency operations. This electronic records policy reflects guidelines set in the North Carolina Department of Cultural Resources publication, *Guidelines for Managing Trustworthy Digital Public Records Version 2.0.* Complying with this policy will increase the reliability and accuracy of records stored in information technology systems, and will ensure that they remain accessible over time. Exhibiting compliance with this policy will enhance records' admissibility and acceptance by the judicial system as being trustworthy.

All public records as defined by North Carolina G.S. § 132-1 are covered by this policy. This includes permanent and non-permanent records, and confidential and non-confidential records. These classifications may warrant different treatments when processing the records.

This policy will supersede any electronic records system policy previously adopted. This policy will be reevaluated according to the schedule in the Policy on Policies and upon the implementation of a new information technology system, and will be updated as required. A copy of this policy will remain on file at the Department of Cultural Resources.

II. POLICY:

This policy serves as basic documentation of the procedures followed by the department in imaging, indexing, auditing, backing up, and purging electronic records in accordance with the disposition schedule, and in handling the original paper record, if applicable.

This policy also serves to protect those records digitized by the agency's imaging system, which reduces required storage space for original documents as the agency transitions to a "paperless" digital system, and provides instant and simultaneous access to documents as needed.

Definitions: N/A

Applicable Law, Rules and References: North Carolina Department of Cultural Resources Division of Archives and Records

Responsible Person(s):

- Agency Supervisor (Director of Nursing, Management Support Supervisor)/Division Director (Health Director)
- IT Department (Rockingham County Local Government IT staff or designees)
- Records Creators

1. **Agency Supervisor (Director of Nursing, Management Support Supervisor)/Division Director (Health Director) - Responsibilities include:**

    a. Determining access rights to the system
    b. Approving system as configured by IT
    c. Ensuring quality assurance checks are completed by sampling the agency's/division's imaged records before the original documents are destroyed
    d. Developing, documenting and administering training specific to the electronic documentation to the Patagonia Health System.

2. **IT Department (Rockingham County Local Government IT staff and/or designee) - Responsibilities include:**

    a. Installing and maintaining equipment and software
    b. Configuring the system according to department needs, including creating and testing applications and indexes
    c. Controlling access rights to the system
    d. Maintaining documentation of system hardware and software
    e. Ensure the review of audit trails that document actions taken on records stored by the information technology system
    f. Providing backups for system records, and recovering deleted imaged records when necessary
    g. Completing disaster recovery backup at least once every two years
    h. Establishing and providing training on equipment, software (including the imaging system), documenting such training, and providing remedial training as needed
    i. Creating and updating procedural guidelines describing the imaging process and equipment.

3. **Records Creators - Responsibilities include:**

    a. Attending and signing off on training conducted by IT staff or by the Department of Cultural Resources
    b. Creating passwords for computers that are long, complex, and frequently changed
    c. Creating and managing electronic records in their purview in

accordance with these policies and other guidance issued by the Department of Cultural Resources, and complying with all IT security policies

d. Reviewing the system records regularly and purging records in accordance with the retention schedule

e. Carrying out day-to-day processes associated with the agency's imaging program, including:
   (1) Designating records to be entered into the imaging system
   (2) Noting confidential information or otherwise protected records and fields
   (3) Removing transient records
   (4) Completing indexing guide form for each record being scanned
   (5) Reviewing images and indexing for quality assurance
   (6) Naming and storing the scanned images in designated folders
   (7) Once approved, destroying or otherwise disposing of original records in accordance with guidance issued by the Department of Cultural Resources.
   (8) Conducting any necessary batch conversions or batch renaming of imaged records

f. Public employees who have been approved to telecommute or use mobile computing devices must:
   (1) Comply with all information technology security policies, including the agency and statewide acceptable use policies, as well as all statutes and policies governing public records
   (2) Backup information stored on the mobile device daily to ensure proper recovery and restoration of data files
   (3) Keep the backup medium separate from the mobile computer when a mobile computer is outside a secure area.

Equipment Required: N/A

Patient Preparation/Teaching/Documentation: N/A

IV. PROCEDURE:

1. **Availability of System and Records for Outside Inspection**

This agency recognizes that the judicial system may request pretrial discovery of the information technology system used to produce records and related materials. Agency personnel will honor requests for outside inspection of the system and testing of data by opposing parties, the court, and government representatives, to the extent required by the North Carolina Public Records Act, G.S. Chapter 132. Records must be available for inspection and audit by a government representative for the full period

required by law and approved records retention schedules, regardless of the life expectancy of the media on which the records are stored. Records must continue to exist when litigation, government investigation, or audit is pending, imminent, or if a court order may prohibit specified records from being destroyed or otherwise rendered unavailable.

In order to lay a proper foundation for the purposes of admitting the agency's electronic records into evidence, the agency will be able to provide up-to-date, detailed documentation that describes the procedural controls employed in producing records; procedures for input control including tests used to assure accuracy and reliability; and evidence of the records' chain of custody. In addition to this policy, such documentation includes:

- Procedural manuals
- System documentation
- Training documentation
- Audit documentation
- Audit trails

The agency will also honor inspection and copy requests pursuant to N.C. G.S. § 132. The agency should produce the records in the order they were created and used in the course of business, and in the format in which they were created. If it is necessary to separate confidential from non-confidential information in order to permit the inspection or copying of the public records, the public agency will bear the cost of such separation.

2. **Maintenance of Trustworthy Electronic Records**

a. **Produced by Methods that Ensure Accuracy**

i. All platforms used by the agency to create and manage electronic records, including email clients, social media platforms, and cloud computing platforms conform with all Department of Cultural Resources' policies and all applicable security policies.

ii. Electronic files are named in accordance with the *Best Practices for File-Naming* published by the Department of Cultural Resources.

- No special characters will be used in a file name. \ / : * ? " < > | [ ] & $, .
- All file names will include all necessary descriptive information independent of where it is stored.
- Dates will be used and formatted consistently.
- A version number will be used on drafts and revisions of documents.
- All standards related to file naming will be followed

consistently.
- Exceptions can be made in situations where a program sets its own parameters on the file names allowed.

Electronic files are saved in formats that comply with DCR's *File Format Guidelines for Management and Long-Term Retention of Electronic Records,* (http://digitalpreservation.ncdcr.gov/file_formats_in-house_preservation.pdf). File formats used by the agency are adopted as standard by the state, and are well-supported, are backwards compatible, and have robust metadata support.

b. **Maintained in a Secure Environment**

Security to the system and to the records it holds is maintained in the following ways:
- Access rights are managed by the IT department, and are determined by a supervising authority to prevent unauthorized viewing of documents.
- The information technology system is able to separate confidential from non-confidential information, or data creators organize and name file systems to reflect confidentiality of documents stored within
- Physical access to computers, disks, and external hard drives is restricted
- Duplicate copies of digital media and system backup copies are stored in offsite facilities in order to be retrieved after a natural or human-made disaster
- Confidential material is redacted by following guidelines set forth by Patagonia before it is shared or otherwise made available.

c. **Associated and Linked with Appropriate Metadata**

Metadata is maintained alongside the record. At a minimum, metadata retained includes file creator, date created, title (stored as the file name), and when appropriate, cell formulae and email header information. Employees are not instructed to create metadata other than metadata that is essential for a file's current use and/or retention.

d. **Stored on Media that is Regularly Assessed and Refreshed**

Data is converted to new usable file types as old ones become obsolete or otherwise deteriorate. The following steps are taken to ensure the continued accessibility of records kept in electronic formats:
- Data is audited and assessed regularly

- Media is refreshed every three to five years. The agency documents when and how records are transferred from one storage medium to another.
- Records are periodically converted to new file types, particularly when a new information technology system requires that they be brought forward in order to properly render the file
- Metadata is maintained during migration
- The number of files will be verified during and after migration. Random file selection will be performed to ensure record quality.
- Storage media should be maintained in a manner and in an environment that promotes bit-level preservation. Humidity should not exceed 50% and should not fall below 30%. Room temperature is set between 65° F to 75° F. The agency adheres to the media manufacturer's recommendations for specific environmental conditions in which the media should be stored.
- Whatever media is used to store imaged data is clearly labeled with enough information that its contents can be determined.

3. **Components of Information Technology System**

a. **Training Programs**

The IT department will coordinate training for system use and electronic records management, using material published by the Department of Cultural Resources when appropriate. All employees will be made aware of system procedures and policies, trained on them, and confirm by initialization or signature acknowledging that they are aware of the policies and have received training on them. When appropriate, employees will also attend trainings offered by the Department of Cultural Resources on the maintenance of electronic records. Documentation will be maintained for the distribution of written procedures, attendance of individuals at training sessions and refresher training programs and other relevant information.

Training specifically related to Patagonia, and the creation of electronic documentation, whether entered directly in the system or scanned in the system, will be created, documented and approved by the Agency Supervisor (Director of Nursing, Management Support Supervisor)/Division Director (Health Director) or ITS Business Analyst.

b. **Audit Trails**

A log of activities on the system is maintained, which show who accessed the system, how and by whom records were created and

modified, and whether standard procedures were followed. **Patagonia maintains these audit trails.**

c. **Audits**

Audits are designed to evaluate the process or system's accuracy, timeliness, adequacy of procedures, training provided, and the existence of audit trails. Internal audits are conducted regularly.

4. **Documentation of Information Technology System**

a. **Content of System Documentation**

The agency maintains system documentation that describes system procedures and actual practices, as well as system software and hardware, and the system environment in terms of the organizational structure, functions and responsibilities, and system processes. It explains how the system operates from a functional user and data processing point of view. Documentation is reviewed and updated annually or upon implementation of a new information technology system by the Agency Supervisor (Director of Nursing, Management Support Supervisor)/Division Director (Health Director) or ITS Business Analyst. Such documentation maintained by the agency includes:

- Procedural manuals
- System documentation
- Security backup and disaster recovery procedures as a part of the Continuity of Operations Plan
- System-level agreements for contracted information technology services

b. **Retention of System Documentation**

One set of all system documentation will be maintained during the period for which the records produced by the process or system could likely be subject to court review, and until all data created by every system instance has been destroyed or transferred to new operating environment. All such documentation is listed in the Rockingham County Department of Health and Human Services Division of Public Health’s records retention schedule.

5. **Digital Imaging Program Documentation and Procedures**

a. **System and Procedural Documentation**

The IT department is responsible for preparing and updating detailed procedures that describe the process followed to create and recreate electronic records. This documentation will include a description of

the system hardware and software. A current procedural manual will be maintained to assure the most current steps are followed and to assure reliable system documentation will be available for judicial or similar proceedings.

Each workstation designated as a scanning station will have, at a minimum, the following hardware and software, unless the scanner is collocated by means of a network interface:

- Document/image scanner authorized by IT (Fujitsu fi-7160)
- Driver software for scanner
- Imaging software (We use Patagonia as our Electronic Health Record. Selected portions of paper records for our active patients are scanned into Patagonia).
- Instructions manual, maintained by IT staff, describing in detail the steps required to get from the beginning to the end of the process. This manual will also define:
    - The resolution of scanned images, as well as any compression standard used
    - The file formats of scanned images
    - The file naming conventions used for scanned images
    - If batch conversion or batch file re-naming will be necessary, and what tool is used for such conversions
    - How the scanned images will be stored in the file system
    - Any image enhancement techniques conducted after imaging

b. **Training**

Only designated staff that have been formally trained by the Agency Supervisor (Director of Nursing, Management Support Supervisor)/Division Director (Health Director) or ITS Business Analyst or designee and signed off on training documentation on the use of the imaging software and equipment will be allowed to enter records into the content management system. Covered records will be scanned and filed as part of an ongoing regularly conducted activity. Components of the training will include basic techniques for image capture, indexing, quality control, security configuration, auditing, use of equipment, and general system maintenance. Rights to image and index records will not be assigned until the user has been trained. If a user improperly indexes or scans a document, an auditor will address this occurrence with the operator and remedial training will be performed as necessary.

c. **Indexing and Metadata**

All imaged records must be indexed in order to facilitate efficient

retrieval, ease of use, and up-to-date information about the images stored in the system. This index should capture the content, structure, and context of the imaged records, and will be developed by the Agency Supervisor (Director of Nursing, Management Support Supervisor)/Division Director (Health Director) or ITS Business Analyst, prior to the implementation of any imaging system. It should also be indexed according to guidelines set by the Department of Cultural Resources in its *Public Database Indexing Guidelines* (see Section 7 of this policy, *Other Electronic Records Management Practices*, for more information on database indexing).

d. **Auditing and Audit Trails**

The imaging staff will conduct a quality control audit following the imaging of a record to ensure that the following features of the imaged record are legible:

- Individual letters, numbers, and symbols
- Combinations of letters, numbers, and symbols forming words or sentences
- Graphics such as signatures, logos, and pictures
- Other features of records such as color, shape, texture, etc., that relate to the content of the information.

Designated staff for the various units of the agency will also periodically audit imaged records for accuracy, readability, and reproduction capabilities. A written audit report will be prepared indicating the sampling of records produced and what remedial procedures were followed if the expected level of accuracy was not achieved.

Audit trails built into the imaging system will automatically document who creates duplicates, modifies, or otherwise prepares records, and what procedures were taken. Audit trails include the success or failure, date, time, and user of the following events:

- Add/Edit electronic document
- Assign index template
- Copy document
- Copy pages
- Create document/folder
- Delete entry
- Delete pages
- Delete volume
- Edit image
- Email document

- Export document
- Index creation/deletion/modification
- Insert page
- Log in/out
- Move document
- Move pages
- Print document
- Document access

e. **Retention of Original and Duplicate Records**

Records scanned and added to an electronic database. If these records are not required for audit or legal purposes, they may be destroyed after completion of data entry and after all verification and quality control procedures.

Destruction of original records is allowed only after quality assurance has been conducted on the imaged records, necessary corrections have been made, auditing procedures have been conducted, and the destruction is approved. Prior to destruction of the original record, managerial staff will audit a sample of those records to verify the accurate reproduction of those records.

Digital images of scanned records are maintained for the specified retention periods according to the records retention and disposition schedule. The retention period is considered to have begun when the original document was created, not when the electronic reproduction was created.

Electronic and digital images of scanned records in a document management system will be considered the "official" agency record.

Any hard copy generated from the imaged records will be considered the agency's duplicate "working" record.

If scanning is outsourced, a copy of the purchase order and a detailed service-level agreement will be maintained. See Section 6 of this policy, *Other Electronic Records Management Practices,* for more information on contracting out electronic records management services.

6. **Request for Disposal of Original Records Duplicated by Electronic Means**

This agency will follow the State Archives of NC general records schedule for local governments for retention and destruction.

7. **Other Electronic Records Management Practices**

a. **System Planning**

- Other agency programs are in various stages of evaluating their needs of document management systems
- Hardware and software update needs are reviewed/planned for annually, per agency policy. This review includes budgetary implications.

b. **Electronic Records Management**

System documentation, system access records, digitization and scanning records, metadata, and information maintained by that system is listed in an approved records retention and disposition schedule prior to their destruction or other disposition.

Records produced by local agencies are retained for the period of time required by local records retention schedules regardless of format. Any permanent records maintained in electronic form also exist as a paper or microfilm preservation duplicate copy in compliance with the Department of Cultural Resources' *Human-Readable Preservation Duplicates* policy.

c. **Database Indexing**

G.S**.** §132-6.1 requires that databases be indexed with the Department of Cultural Resources. Indexes contain the following data fields:

- Description of the format or record layout
- Frequency with which the database is updated
- List of any data fields to which public access is restricted
- Description of each form in which the database can be copied or reproduced using the agency's computer facilities
- Schedule of fees for the production of copies in each available form

d. **Security and Disaster Backup and Restoration**

The agency has a disaster recovery plan for its electronic data in place, which includes contact information for data recovery vendors and information about back-ups of all data. Security back-ups to protect against data loss are generated for all but the most transitory of files.

For Patagonia, a totally web-based system, all data is automatically saved every couple minutes. All Patagonia health data is stored in commercial SAS 70 Type II compliant data centers. There is a primary site in NC and a back-up site in Ohio. Data is automatically

backed up every hour and it is also backed up every night into an external cloud-based system. If anything should happen to a data center, it automatically switches to back-up.

For Dentrix, the back-up is performed per the ITS schedule. ITS is contacted to restore Dentrix.

e. **Cloud Computing - Contracting**

The terms of the service level agreement with Patagonia detail:

- How the vendor provides security, confidentiality, storage, and back-ups for electronic records.
- The equipment, including hardware and software, used by the vendor
- The storage environment, including any geographically disparate storage locations
- How the vendor complies with records retention requirements, including what the contractor is able to reproduce should legal proceedings or public records requests be issued. There is no purging of any records, electronic or scanned. All information in the EHR is stored in commercial data centers and resides there forever unless transferred at request of our agency due to service termination.
- How the vendor avoids spoliation of evidence once e-discovery has commenced. There is no purging of any records, electronic or scanned. All information in the EHR is stored in commercial data centers and resides there forever unless transferred at request of our agency due to service termination.
- How electronic records are to be recovered from the vendor in the event that the system is no longer supported Patagonia Health can transfer data in federally defined CCD/CCR format. The data can then be transferred to another federally certified EHR.

8. **Compliance and Electronic Records Self-Warranty**

The completion of this form by all signing employees' signals that all employees of the unit/section/division will adhere to the rules set forth in this policy. Furthermore, this section is to be used as a self-evaluation tool to ensure that electronic records produced by state, county, municipal agencies, and other subdivisions of government are created, reproduced, and otherwise managed in accordance with guidelines for electronic public records published by the North Carolina Department of Cultural Resources. The self-warranting of records in itself does *not* authorize the destruction of

records, originals or copies, *nor* does it change current records retention and disposition scheduling procedures.

The government agency producing electronic records and/or reproductions is responsible for ensuring the records' authenticity and accuracy. The Department of Cultural Resources is not responsible for certifying the authenticity or accuracy of any records, whether originals or reproductions, produced by the originating agency.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: POSITION DESCRIPTION POLICY

DATE DEVELOPED: 10/18
REVIEWED: 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

Position descriptions will be reviewed by the supervisor and employee at the time of the employee's hire and a copy of their position description will be given to the employee at that time. Position descriptions will be reviewed at six months and then annually at the employee performance evaluation. Supervisors will provide instructions to the employee to review and prepare any proposed revisions to the position description prior to their performance evaluation conference with their supervisor. Proposed revisions will be reviewed by the supervisor and unit supervisor (if applicable). Revisions will be made if appropriate.

The supervisor will secure the necessary signatures and dates from the employee, the supervisor and the unit supervisor (if applicable), and will submit the updated position description with the performance evaluation to the health department personnel technician.

If significant changes in duties and responsibilities indicate possible reclassification, the requested classification will be indicated on the title page of the position description under requested classification and marked for reclassification when submitted to the health department personnel technician. Reclassification requests are to be approved by the Health Director prior to submission. Completed position descriptions and performance evaluations are to be submitted to the health department personnel technician no later than the designated due date set forth.

II. PURPOSE:

A. To ensure that position descriptions are reviewed by the employee and supervisor annually and revised as appropriate.

B. To ensure that an updated position description is reviewed with new employees including an updated title page with the correct employee name, position title and position number; and an updated signature page with the employee and supervisors signatures and dates.

C. To ensure that each employee is provided a copy of their position description at the time of their employment and in the event of any revisions.

D. To ensure that an updated and accurate position description is on file with the health department administrative staff.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMPLOYEE PERFORMANCE APPRAISAL IN THE NEOGOV SYSTEM

DATE DEVELOPED: 10/18
REVIEWED: 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

Performance evaluations will be completed by the supervisor and employee at the six month probationary period and then annually. The evaluation will be created by Human Resources personnel in the Neogov system electronically. The supervisor of the employee four weeks prior to due date; will receive an email notification along with the employee.

The employee will complete the self-rating process prior to the supervisor rating the employee within the Neogov system. Three weeks before evaluation is due the supervisor will receive an email to complete the evaluation. After the supervisor has submitted the evaluation of the employee, it will go through the approval process. Once everyone on the approval chain has approved the evaluation, the supervisor will receive an email stating the evaluation has passed the approval process.

Next step is the supervisor will have a performance evaluation meeting with the employee, to discuss the evaluation. After this meeting the employee will sign off on the evaluation via electronic signature Neogov. The supervisor then needs to print the evaluation and a copy is given to the personnel technician to place in the personnel file within the department. This completes the evaluation process.

II. PURPOSE:

A. To ensure that the performance appraisals are completed at the probationary six months then annually for all employees.

B. To ensure all parties involved understand the steps to completing the performance appraisals.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

ADMINISTRATIVE MANAGEMENT SUPPORT ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance. An understanding of these topics is essential to understanding the function of the Health Department. See job description for responsibility of these duties.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A. Division of Public Health Services - 1. Mission, vision, goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B. Review of Policies 1. Agency Safety a. Fire Prevention and Plan b. Smoke Sensors c. Fire Extinguishers d. Exit Signs e. Security f. Tornado Plan g. Emergency Preparedness - Automatic External Defibrillator - Management Support Disaster Training - Management Support Disaster Assistance - Emergency Shelters and Team Assigned 2. Personal Safety a. Agency worksite b. Home Visiting/Field Work c. Vehicle safety d. Threatening behavior e. Medical emergencies - Clients - Employees - Staff training for: CPR Automatic External Defibrillator		

Infection Control 3. Infection Control a. Personal hygiene b. Aseptic Technique c. Communicable disease d. Precautions e. Cleaning, disinfecting and transporting equipment f. Storing and handling supplies g. Standard precautions h. Blood borne pathogens i. Vaccinations - TB Skin Test - Hepatitis B or Waiver - Rubella - Tetanus - Influenza - Varicella j. Equipment management - Vaccine transporting - Handling and storage k. Identifying, handling and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment - Disposal of needles - Gloves - Impermeable gown - Vent mask - Antibacterial hand wash - Spill kit - N-95 Respirator Mask - Goggles/Face shield		
4. Screening and Reporting for Abuse and Neglect		
5. Community Resources and Collaboration		
6. Continuing Education Requirements		
7. Employee Performance Evaluation		
C. Quality Improvement 1. Quality Improvement Council and Purpose 2. Call supervisor by 7:00 am if not reporting to work 3. Job Description 4. Monitoring/Tracking Performances a. Client satisfaction surveys b. Program quarterly audits c. Incident reports d. Blood borne pathogen exposure e. Client complaints f. CPT/ICD 10		

- Chargeable - Non-Chargeable		
D. Preceptor Assigned – works with and under direction of preceptor		
E. Orientation Period – write in dates (one month)		
F. Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable) 4. Pager system 5. Scope of services and program policy review 6. Service/Program Record a. Documentation System b. Documentation - How to correct entries - Writing neat and legible - Lab Reports – if applicable - Consent forms/Release of information - Consent to photograph – if applicable - Agency approved abbreviations - Review record retention guidelines - Record release policies		
G. Administrative Management Support Staff Performance of Duties 1. Reviews expectations of the assigned role 2. Reviews state and local agency guidelines for assigned role 3. Cross trains in performing a variety of administration duties to assist other disciplines a. Assigning pool vehicles b. Assist in reserving conference and classrooms c. Assist staff by trouble shooting problems with department's fax machine and printer		
H. Expectations of the Management Support Staff Role 1. Report to work-site as assigned in a timely manner 2. Use appropriate communication skills 3. Document and enter data appropriately 4. Accounts for all work hours through leave records, time sheets and mileage sheets 5. Reviews and updates job description annually 6. Adheres to dress code – displaying a professional appearance or worksite appropriate attire 7. Establishes an effective working relationship with others 8. Reliable in following procedures/policies 9. Provides management support services to clients/staff according to standards, program guidelines and collaborates with other health department staff or		

community resources 10. Treats public with courtesy and respect 11. Maintains complete confidentiality of client/staff information – where applicable 12. Accreditation Process – Development, Implementation, and Maintenance		

*When completed the supervisor needs to file.

*The Orientation Checklist should be completed at the end of the employee's probationary status.

Employee's Signature:_____ Date_____

Supervisor's Signature:_____ Date_____

Date Developed: 10/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

CLINICAL MANAGEMENT SUPPORT ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A. Division of Public Health Services - 1. Mission, vision, goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B. Review of Policies: 1. Agency Safety a. Fire prevention and plan b. Smoke sensors c. Fire Extinguishers d. Exit Signs e. Security f. Tornado Plan g. Emergency Preparedness - Automatic External Defibrillator - Management Support Disaster Training - Management Support Disaster Assistance - Emergency Shelters and Team Assigned		
2. Personal Safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies - Clients - Employees - Staff training for: CPR Automatic External Defibrillator Infection Control		
3. Infection Control a. Personal Hygiene		

b. Aseptic Technique c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, and Transporting Equipment f. Storing and Handling Supplies g. Standard Precautions h. Blood borne Pathogens i. Vaccinations • TB Skin Test • Hepatitis B or Waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management • Vaccine transporting • Handling & Storage k. Identifying, handling, and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment • Disposal of Needles • Gloves • Impermeable Gown • Vent Mask • Antibacterial Hand wash • Spill Kit • N-95- Respirator Mask • Goggles/Face Shield		
4. Screening and reporting for abuse & neglect		
5. Community Resources and Collaboration		
6. Continuing Education Requirements		
7. Employee Performance Evaluation		
C. Quality Improvement 1. Quality Improvement Council and Purpose 2. Call supervisor by 7:00am if not reporting to work 3. Job Description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Quarterly Audits c. Incident Reports d. Blood borne Pathogen Exposure e. Client Complaints f. CPT/ICD 10		

- Chargeable - Non-Chargeable		
D. Preceptor Assigned		
E. Orientation Period		
F. Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable) 4. Pager system 5. Scope of services and program policy review 6. Service/Program Record a. Documentation System b. Documentation - How to correct entries - Writing neat and legible - Lab Reports – if applicable - Consent forms/Release of information - Consent to Photograph - if applicable - Agency Approved abbreviations - Review record retention guidelines - Record release policies		
G. Clinical Management Support Staff Performance of Duties 1. Reviews expectations of the assigned role 2. Reviews state and local agency guidelines for assigned role 3. Cross trains in performing a variety of administration duties to assist other disciplines a. Assigning pool vehicles b. Assist in reserving conference and classrooms c. Assist staff by trouble shooting problems with department's fax machine and printer		
H. Expectations of the Clinical Support Staff Role 1. Report to work-site as assigned in a timely manner 2. Use appropriate communication skills 3. Document and enter data appropriately 4. Accounts for all work hours through leave records, time sheets and mileage sheets 5. Reviews and updates job description annually 6. Adheres to dress code – displaying a professional appearance or work-site appropriate attire 7. Establishes an effective working relationship with others 8. Reliable in following procedures/policies 9. Provides management support services to		

clients/staff according to standards, program guidelines and collaborates with other health department staff or community resources 10. Treats public with courtesy and respect 11. Maintains complete confidentiality of client/staff information – where applicable 12. Accreditation Process – development, implementation, and maintenance		

* When completed submit to the supervisor for filing.

* The Orientation Checklist should be completed at the end of the employee's probationary status.

Comments: _____

_____

Employee's Signature: _____Date: _____

Supervisor's Signature: _____Date: _____

Date Developed: 10/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Administrative Management Support Staff

Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Administrative Management Support staff applies theoretical concepts in collaboration with the county, local, state requirements.						
	B.	The Administrative Management Support staff assists the Departmental staff to systematically collect and complete data that is comprehensive and accurate.						
	C.	The Administrative Management Support staff processes data about the individual payroll, insurance, and requests for supplies.						
	D.	The Administrative Management Support staff in collaboration with the Program Staff assist to collect and complete all required documentation payroll time sheets, travel reimbursements, address changes, educational training records, personal and financial records.						
	E.	The Administrative Management Support staff in collaboration with the courts, local, and state agencies assists to implement updates to personnel, payroll, employee reimbursement and financial information as applicable to the individual.						
	F.	The Administrative Management Support staff collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	G.	The Administrative Management Support staff reports to workstation as assigned in a timely manner.						
	H.	The Administrative Management Support staff introduces self to client when interacting with client services.						
	I.	The Administrative Management Support staff uses appropriate communication techniques to make client/staff comfortable, addresses client/staff questions, concerns and telephone calls with dignity and respect.						
	J.	The Administrative Management Support staff may facilitate the flow of clients through the department’s programs to promote accessibility of services, decrease wait time, and provide high quality services.						
	K.	The Administrative Management Support staff will demonstrate familiarity with the forms and paperwork.						
	L.	The Administrative Management Support staff effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	M.	The Administrative Management Support staff demonstrates support of agency by involvement in community activities.						
	N.	The Administrative Management Support staff uses chain of command for problem resolution.						

	O.	The Administrative Management Support staff adheres to dress code policy.							
	P.	The Administrative Management Support staff maintains a reliable attendance record.							
	Q.	The Administrative Management Support staff demonstrates competency in accurately filing of personnel, financial, accounting data entry and individual training records of departmental staff records.							
	R.	The Administrative Management Support staff demonstrates thorough knowledge of daily operation of the software systems associated with individual job responsibilities.							
	S.	The Administrative Management Support staff demonstrates accurate participation in their role of the billing cycle. 1. Review of encounters 2. Revenue cycle and actual billing procedures 3. Accounts Receivable procedures 4. Records of collections							
	T.	The Administrative Management Support staff demonstrates thorough knowledge of computer skills, maintaining proficiency and accuracy.							
	U.	The Administrative Management Support staff demonstrates knowledge of medical terminology and spelling.							
	V.	The Administrative Management Support staff demonstrates proficiency in general office procedures.							
	W.	The Administrative Management Support staff demonstrates ability to assist in the retrieval of statistical information for all departmental programs.							
	X.	The Administrative Management Support staff demonstrates thorough understanding of mail process and distribution services.							
	Y.	The Administrative Management Support staff adheres to agency's policies and procedures - reviews annually.							
	Z.	The Administrative Management Support staff properly completes all required documentation within a timely manner using correct program department, county, local and state policy and procedures.							
	AA.	The Administrative Management Support staff is knowledgeable and maintains client/staff rights and confidentiality.							
	BB.	The Administrative Management Support staff demonstrates understanding and implementation of HIPAA compliance.							
II.		**Infection Control Measures:**							
		Hand washing							
		1. Washes hands at least 30 seconds under running water.							
		2. Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.							
		3. Keep fingers pointed down, lower than wrists to prevent contamination of the arms.							
		4. Rinse hands under running water-allowing water to flow from the upper arm down over the hands.							
		5. Dry hands thoroughly with a dry paper towel.							
		6. Use a separate paper towel to turn off the faucet.							

		7.	Use lotion to prevent drying of the skin.						
		8	Use gel or foam cleanser to wash hands only until you can use running water.						
	A.	Universal Precautions							
	B.	Has attended annual training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.							
	C.	Demonstrates an understanding of and practices universal precautions.							
	D.	Demonstrates an understanding of modes of transmission of blood borne diseases.							
	E.	Demonstrates knowledge and selection of personal protective equipment.							
	F.	Practices hand washing to prevent spread of disease.							
	G.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.							
III.	**Skills Performance - Body Mechanics:**								
	A.	Sitting:							
		1.	Position buttocks against the back of chair.						
		2.	Place feet flat on floor at 90-degree angle to lower legs.						
		3.	Flexes hip slightly so knees are higher than ischial tuberosities.						
		4.	Flexes lumbar spine slightly.						
		5.	Flexes elbows and places forearms on armrest, if applicable.						
	B.	Standing:							
		1.	Keeps feet parallel 6 inches to 8 inches apart.						
		2.	Places equal weight on both legs.						
		3.	Flexes knees slightly.						
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.						
	C.	Walking:							
		1.	Assumes the correct standing position.						
		2.	Steps forward a comfortable distance with one leg.						
		3.	Tilts the pelvis slightly forward and downward.						
		4.	Touches floor first with heel then ball of foot to toes.						
		5.	Advances the other arm and leg to promote balance.						
	D.	Pulling:							
		1.	Stands close to the object.						
		2.	Places one foot slightly ahead of the other.						
		3.	Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscle.						
	E.	Pushing:							
		1.	Places hands on object and flexes the elbows.						
		2.	Leans into the object by shifting weight from back leg to front leg.						
		3.	Applies smooth continuous pressure.						
	F.	Stooping:							
		1.	Stands with feet 10-13 inches apart.						
		2.	Places one foot slightly ahead of the other.						
		3.	Lowers self by flexing the knees.						
		4.	Places more weight on front foot than back.						

		5. 6.	Keeps upper body straight (does not bend at the waist). Straightens knees keeping the back straight.							
	G.	Lifting and Carrying:								
		1. 2. 3. 4.	Assumes stooping position directly in front of the object. Grasps object and tightens abdominal muscles. Stands up straight by straightening the knees. Carries the object close to the body waist high.							

Comments: _____

_____

_____ successfully demonstrates the above criteria in the work setting.
Employee

_____ _____
Employee Signature & Date Reviewer's Initials & Date

_____ _____
Employee Signature & Date Reviewer's Initials & Date

_____ _____
Employee Signature & Date Reviewer's Initials & Date

Issued: 3/02
Reviewed 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/18

Rev/di

The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC SERVICES

Clinical Management Support Staff

Competency Skills Checklist

	SUBJECT		DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Management Support staff applies theoretical concepts in collaboration with the MOA, LPN, RN, or Physician Extender.						
	B.	The Management Support staff assists the Nursing and Physician Extender staff to systematically collect and complete data that is comprehensive and accurate.						
	C.	The Management Support staff assists in processing data about the community, family and individual.						
	D.	The Management Support staff in collaboration with the LPN/RN/Physician Extender intervenes to promote, maintain or restore health, to prevent illness, to minimize complications and effect rehabilitation.						
	E.	The Management Support staff in collaboration with the LPN/RN/Physician Extender evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	F.	The Management Support staff may participate in peer review and program audits to assure quality of services.						
	G.	The Management Support staff collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	H.	The Management Support staff reports to workstation as assigned in a timely manner.						
	I.	Management Support staff introduces self to client when interacting with client services.						
	J.	The Management Support staff uses appropriate communication techniques to make client comfortable, addresses client questions, concerns and telephone calls with dignity and respect.						
	K.	The Management Support staff may facilitate the flow of clients through the clinic to promote health care accessibility, decrease wait time, and provide high quality services.						
	L.	Management Support staff may demonstrate familiarity with the client record and chart composition.						
	M.	Management Support staff effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	N.	Management Support staff demonstrates support of agency by involvement in community activities.						
	O.	Management Support staff uses chain of command for problem resolution.						
	P.	Management Support staff adheres to appropriate dress and grooming.						

	Q.	Management Support staff maintains a reliable attendance record.						
	R.	Management Support staff demonstrates competency in accurately filing of clinical records.						
	S.	Management Support staff demonstrates thorough knowledge of daily operation of the computer system.						
	T.	Management Support staff demonstrates accurate participation in their role of the billing cycle. 1. Data entry for encounters 2. Data entry/actual billing procedures						
	U.	Management Support staff demonstrates thorough knowledge of typing skills, maintaining proficiency and timely manner.						
	V.	Management Support staff demonstrates thorough knowledge of medical terminology and spelling.						
	W.	Management Support staff demonstrates ability to transcribe Physician Extender recorded notes accurately.						
	X.	Management Support staff demonstrates proficiency in general office procedures.						
	Y.	Management Support staff demonstrates ability to retrieve statistical information as needed.						
	Z.	Management Support staff demonstrates thorough understanding of mail process and distribution services.						
	AA.	Management Support staff adheres to agency's policies and procedures - reviews annually						
	BB.	Management Support staff properly completes all required documentation on assigned clients within a timely manner using correct medical terminology.						
	CC.	Management Support staff is knowledgeable and maintains client rights and confidentiality.						
	DD.	Management Support staff implements measures to maintain client confidentiality.						
	EE.	Management Support staff demonstrates understanding and implementation of HIPAA compliance.						
II.		**Infection Control Measures:**						
		Hand washing 1. Washes hands at least 30 seconds under running water. 2. Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap. 3. Keep fingers pointed down, lower than wrists to prevent contamination of the arms. 4. Rinse hands under running water-allowing water to flow from the upper arm down over the hands. 5. Dry hands thoroughly with a dry paper towel. 6. Use a separate paper towel to turn off the faucet. 7. Use lotion to prevent drying of the skin. 8 Use gel or foam cleanser to wash hands only until you can use running water.						
	A.	Disposal of soiled materials						
	B.	Disposal of excretions						
	C.	Universal Precautions						
	D	Has attended annual training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.						

	E.	Demonstrates an understanding of and practices universal precautions.							
	F.	Demonstrates an understanding of modes of transmission of blood borne diseases.							
	G.	Demonstrates knowledge and selection of personal protective equipment.							
	H.	Practices hand washing to prevent spread of disease.							
	I.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.							
		Standard Precautions							
		1. Assemble equipment							
		2. Wash hands							
		3. Uses protective barrier precautions (mask, protective eyewear, gowns, gloves) as appropriate to prevent contact with client's body/blood fluids.							
		4. Disposes of all needles/sharps in appropriate container. Fills sharps container only to 2/3 capacity.							
		5. Secures lid on capacity filled container and place container on shelf in lab work-up room for disposal.							
		6. Disposes of soiled linen properly.							
		7. Knows location of and usage for spill kit. Nursing home visiting staff keeps spill kit in their car.							
III.	**Skills Performance - Body Mechanics:**								
	A.	Sitting:							
		1. Position buttocks against the back of chair.							
		2. Place feet flat on floor at 90-degree angle to lower legs.							
		3. Flexes hip slightly so knees are higher than ischial tuberosities.							
		4. Flexes lumbar spine slightly.							
		5. Flexes elbows and places forearms on armrest, if applicable.							
	B.	Standing:							
		1. Keeps feet parallel 6 inches to 8 inches apart.							
		2. Places equal weight on both legs.							
		3. Flexes knees slightly.							
		4. Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.							
	C.	Walking:							
		1. Assumes the correct standing position.							
		2. Steps forward a comfortable distance with one leg.							
		3. Tilts the pelvis slightly forward and downward.							
		4. Touches floor first with heel then ball of foot to toes.							
		5. Advances the other arm and leg to promote balance.							
	D.	Pulling:							
		1. Stands close to the object.							
		2. Places one foot slightly ahead of the other.							
		3. Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscle.							
	E.	Pushing:							
		1. Places hands on object and flexes the elbows.							
		2. Leans into the object by shifting weight from back leg to front leg.							

		3.	Applies smooth continuous pressure.						
	F.	Stooping:							
		1.	Stands with feet 10-13 inches apart.						
		2.	Places one foot slightly ahead of the other.						
		3.	Lowers self by flexing the knees.						
		4.	Places more weight on front foot than back.						
		5.	Keeps upper body straight (does not bend at the waist).						
		6.	Straightens knees keeping the back straight.						
	G.	Lifting and Carrying							
		1.	Assumes stooping position directly in front of the object.						
		2.	Grasps object and tightens abdominal muscles.						
		3.	Stands up straight by straightening the knees.						
		4.	Carries the object close to the body waist high.						

The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

_____ successfully demonstrates the above criteria in the work setting.
Employee

_____ _____
Employee Signature & Date Reviewer's Initials & Date

_____ _____
Employee Signature & Date Reviewer's Initials & Date

_____ _____
Employee Signature & Date Reviewer's Initials & Date

Issued: 3/02
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

ADULT HEALTH PROGRAM

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ADULT PRIMARY CARE CLINIC

DATE DEVELOPED: 9/1/92
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/18; 6/19; 6/21; 6/23; 6/24

I. POLICY:

The Division of Public Health Services will provide primary care services to adults aged 21 years or over who reside within the jurisdiction of the Division of Public Health.

II. PURPOSE:

A. To reduce morbidity/mortality rates by prevention, through early detection, treatment, education and proper referral of clients with risk factors and disease processes.

B. A local health department shall provide, contract for the provision of, or certify the availability of adult health services for all individuals within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

1. A description of the availability of adult health services shall be maintained. These shall include the following prevention and detection services for cancer, diabetes, and hypertension.

   - Identification, recruitment, screening, including laboratory services, referral, and follow-up;
   - Nutrition services to patients and persons at risk.

2. A description of the target population for adult health services provided by the local health department, including eligibility criteria.
3. A description of fees, if any, for adult health services provided by the local health department. A local health department shall establish, implement, and maintain written policies for the provision of health education services to the community, persons at risk, and patients.

III. GUIDELINES:

A. Hours of Operation

Adult Primary Care is offered by appointment 8:00 a.m. to 5:00 p.m. Monday through Friday. Night clinic hours are from 5:00 p.m. to 7:00 p.m. on **most** Thursdays. Clients without appointments may be worked in as the schedule allows. A physician supervised night clinic may be made

available monthly from 5:00 p.m. to 7:00 p.m. The day of the week is determined by the Advanced Practice Provider (APP) and the Physician.

B. After Hours Care

After hours and weekend holiday coverage is provided by RNs and APPs of the Division of Public Health Services on a rotated system. Division of Public Health Services Carolina Access clients are given the information to contact staff if needed.

Clients not under Division of Public Health Services Carolina Access are instructed to seek care during evening and weekend hours from a health care provider of their own choosing and at their own cost.

C. Financial Eligibility

1. Division of Public Health Services offers Adult Primary Care as part of its health services to citizens of Rockingham County. It is the intent of this program to offer all services to eligible adults, who are approved under guidelines established for the APP by the Joint Medical Board and as appropriate, a complete medical history, and physical examination, performing and / or ordering and interpreting laboratory studies in order to diagnose illnesses. Appropriate treatment or referral and the prescribing of appropriate medications are included in services offered.

2. Financial Eligibility will be based upon verification of income policy.

3. All Medicaid recipients are eligible for Adult Primary Care clinic. All other adult eligibility will be determined according to the health department fee schedule.

    a. No client will be denied services due to inability to pay. Financial eligibility will be obtained prior to services being rendered. If the client has private insurance, the client/family member will be informed of their options.
    b. The client will be informed of the choice to receive these services through their preferred provider and pay the co-pay.
    c. The client/family member will be informed that the private insurance carrier may be billed. In the event, the insurance source denies payment, the client will be billed the charges according to the fee schedule.

4. Uninsured clients who are seen in the Adult Primary Care Clinic will be charged for services based on the Sliding Fee Scale set under the Fee and Eligibility Policy (B-1). However, laboratory services will be charged at 100%.

5. No person, on the grounds of race, color, age, religion, creed, sexual orientation, political affiliation, national origin, or physical handicap, will be denied services or benefits.

6. Client will be informed that the Division of Public Health Services will provide services as requested and their financial responsibilities will be based on their financial eligibility. Charges will be generated according to the current Sliding Fee Scale.

D. Scheduling

1. Appointments are generally scheduled; however, acute illness, telephone triage, or walk-ins may be seen.

2. Management support staff or the EHR Communicator Application will remind clients of their appointments prior to the appointment date via text message or automated phone call.

E. Clinical Records for Adult Primary Care Clients

1. The established record system utilizes the Division of Public Health Services Clinical Records Policy. The records are kept in a central file. HIPAA regulations are enforced. Refer to policies:

   a. Use or disclosure of Protected Health Information with an Authorization Policy.
   b. Using and Disclosing Protected Health Information without Individual Permission Policy, which are located in the HIPAA Policy Manual.

2. A management support person is responsible for management of the paper files. On the initial visit management support establishes eligibility and registers the client within the electronic health record (EHR).

3. Retention of the records follows the schedule of the Records Disposition Schedule as published by the Division of Archives and History.

4. The clients' medical records are pulled by management support only at the request of the APP/or nurse.

5. All clinical records are kept secure in one of two (2) areas: 1) in portable locked carts or file cabinets kept within APP's offices, or 2) in a locked file cabinet in Room 30.

   During the day the carts and file cabinets are unlocked for access, but the office doors are closed to meet HIPAA guidelines. Overnight, all carts and file cabinets are locked and secured.

F. Duties of the APP/Provider Work-Up Nurse

1. Referrals:

   The APP refers clients who need more intense and specialized services to appropriate medical resources of their choice.

2. Physical Exams:

   All annual, or otherwise, physicals for clients with known problems; chronic disease(s); or for any other reasons related to problem issues, must be done by the APPs.

3. The APP performs a variety of functions in the area of adult health.

   a. This care involves making independent judgments in the health care of adults.
   b. Plans and develops methods, practices and approaches pertinent to adult health in adult primary care clinics.
   c. Secures complete health histories, including family; social; medical; history of current problem/illness, description of onset, characteristics of symptoms, course since onset and current status, condition prior to onset, and the affect of any therapy/home remedy used. This information may have been compiled initially by the nurse.
   d. Performs comprehensive adult assessments as it relates to chief complaint.
   e. Educates, advises, and counsels clients concerning problems, risk behaviors, and mental and physical health care instructions.
   f. The immunization history and status is reviewed and immunizations are updated as indicated.
   g. Educates family members/caregivers regarding any treatments or procedures that need to be done, which the client cannot do for her/himself.
   h. Orders laboratory studies and/or X-rays when appropriate.
   i. Arranges for consultation and/or referral of care to physician, or to other health team member, when necessary.
   j. Coordinates health care of client with family, if indicated and with other professionals and agencies.
   k. Identifies resources within the community to help clients, and guides the client in the use of identified resource.
   l. Prescribes selected medications, according to protocol and/or consultation. The APP prescribes appropriate medications for illnesses diagnosed in the Adult Primary Care Program. Clients may take these prescriptions to the pharmacy of their choice in the same manner they would from any private medical resource.

Clients unable to purchase their own medications due to financial limitations may receive a one-time free assistance medication from the Division of Public Health Services Pharmacy if stocked at the Pharmacy. With prescriptions for adult medications that are carried in the Pharmacy, there is at least a $4.00 charge for generic medications for which the client is responsible for paying.

The Division of Public Health Services Pharmacy has a grant to assist adult clients who qualify for the Prescription Assistance Program (PAP). Adult clients are referred by the APP to the PAP Coordinator for these services; these clients must financially qualify for this PAP assistance.

Uninsured clients who meet eligibility guidelines may receive medications from the Dispensary of Hope Program free-of-charge if available at the time of visit.

m. Lab and other diagnostic services: The Adult Primary Care Program is able to provide the following lab and diagnostic procedures: hemoglobin, urinalysis, throat culture, blood sugar, serologies, parasitology, EKG, wet preps, STD screening tests, and Pap smears as indicated. Additional laboratory procedures that are not routine tests of the primary care program may be handled on a referral basis to a private referral lab. The client may incur costs of diagnostic labs or procedures obtained at the local hospital or referral laboratories. X-rays are referred to a local hospital.

4. Follow-up:

a. The APP schedules return appointments as appropriate, for on-going follow-up of all clients. Clients may remain within the Adult Primary Care system for their medical care as long as they qualify financially, or until the client withdraws from the program by his/her choice, or until the client moves to another county or state, or until discharged from practice.

b. The responsibility for keeping scheduled follow-up/recheck appointments is placed on the adult client.

5. Documentation:

The APP is to record all clinical notes in the EHR on every client seen in the Adult Primary Care Clinic immediately after clinic visit has concluded with client or as soon as possible thereafter (but no later than 2 business days).

6. APP-Physician Consultation:

The following review and counter-signing of notations by a primary supervising physician shall include, but is not limited to:

a. Any client with complex, multiple health problems that the APP believes needs the physician consultation, collaboration, referral and evaluation of care.
b. Documentation of consultation shall:
   i. Identify clinical issues discussed and actions taken.
   ii. Maybe signed and dated by the APP and supervising physician.
   iii. Be available for review by members or agents of either board for the previous five calendar years and be retained by both the APP and the physician.
c. These clinical records may be transported in a secured, locked, portable file box, which is placed in the trunk of the vehicle. If the vehicle does not have a trunk, the chart file box is placed on the floor in the rear of the vehicle or transmitted via way of the EHR.
d. Scope of services and program policies review *21 NCAC – 32M .0102 Scope of Practice Rules of NC Medical Board.*

   The APP/Physician Assistant shall be responsible and accountable for the continuous and comprehensive management of a broad range of personal health services for which the APP is educationally prepared and for which competency has been maintained, with physician supervision and collaboration as described in *21 NCAC32m.0109*. These services include, but are not restricted to:

   - Promotion and maintenance of health
   - Prevention of illness and disability
   - Diagnosing, treating and managing acute and chronic illnesses
   - Guidance and counseling for both individuals and Families
   - Prescribing, administering and dispensing therapeutic measures, tests, procedures and drugs
   - Planning for situations beyond the APP's expertise and consulting with and referring to other health care providers as appropriate, and evaluating health outcomes

e. Quality Assurance Process for APP:

   The Primary Supervising Physician and the APP shall develop a process for the on going review of the care provided in each practice site to include a written plan for evaluating the quality of care provided for one or more frequently encountered clinical problems. This plan shall

include a description of the clinical problem(s), an evaluation of the current treatment interventions, and if needed, a plan for improving outcomes within an identified timeframe. This will also include scheduled meetings between the Primary Supervising Physician and the APP at least every six months.

Documentation for each meeting shall:

(1) Identify clinical problems discussed which also includes progress toward improving out comes and recommendations for changes in treatment plan.
(2) Be signed and dated by those attending.
(3) Be available for review within five calendar years and be retained by both the APP and the physician.

G. The Adult Primary Care APP(s) provide services under the supervision and direction of the medical consultants. The medical consultants are contacted for back-up services, as needed.

H. <u>Prescribing Standards</u>

1. The APP who has active approval may prescribe and order the administration of medications at the Division of Public Health Services.

2. The APP may prescribe with the following stipulations:

a. Drugs and devices prescribed in the practice site shall be included in written protocols.
b. Controlled substances (schedules II, IIN, III, IIIN IV, V) defined by the State and Federal controlled substances Act may be procured, prescribed, or ordered as established in written protocols if the following requirements are met:

(1) The APP's assigned DEA number must be entered on each prescription.
(2) Dosage units for schedules II, IIN, III, and IIIN are limited to a 30-day supply.
(3) Schedules II and IIN controlled substances may not be refilled.
(4) Schedules III and IIIN controlled substances may be refilled 5 times within a 6 month time period.

3. The APP may prescribe a drug not included in the site-specific written protocols only as follows:

a. Obtain a specific written or verbal order from the primary or back-up supervising physician.
b. The written or verbal order shall be entered into the client's record with a notation that it is issued on the specific order of the primary or supervising physician and signed by the APP and physician.

4. Refills may be issued not to exceed one year except for controlled substances, which may not be refilled.

5. Each prescription shall be documented in the client's record with the following information:

   a. Medication and dosage
   b. Amount prescribed
   c. Directions for use
   d. Number of refills
   e. Signature of APP

6. The prescribing number assigned by the Medical Board to the APP must appear on all prescriptions issued by the APP.

7. Prescription format:

   a. Supervising Physician(s) name
   b. Name of the client
   c. APP's name, telephone number and prescribing number
   d. APP's assigned DEA number shall be written on the prescription form when a controlled substance is prescribed.

8. The APP may obtain approval to dispense the drugs and devices included in the written protocols for each practice site from the Board of Pharmacy and dispense in accordance with 21 NCAC46.1700.

   Reference:
   North Carolina Administrative Code: Subchapter 32M-Prescribing Authority of the Nurse Practitioner (T21: 32M.0109)
   Administrative Code: Subchapter 32S-Prescriptive Authority of the Physician Assistant (T21: 32S.0212)

9. Clients can take these prescriptions to the pharmacy of their choice in the same manner they would from any private medical resource. Local resources are utilized for clients unable to purchase their own medications due to financial limitations.

10. Clients may be referred to the Prescription Assistance Program within the Division of Public Health for on-going financial needs in

obtaining long-term prescriptions. These clients must qualify financially for this program.

I. Adult Primary Care/Adult Health Policy – Laboratory, Pap Smear, and Mammogram Results

1. When a Pap smear result comes back from the lab, the APP will review the results and determine any follow-up. A designated management support person is responsible for notifying the clients of their abnormal results and plans for follow-up. Clients will be instructed that they will not be notified if results are normal. After 3 unsuccessful attempts to contact client with abnormal Pap results, a certified letter will be sent.

2. When a client has a mammogram the agency completing the procedure will notify the client of results and any need to follow-up.

3. The APP will notify clients by phone or letter of any significant abnormal lab results and plan of care.

J. Quality Assurance Standards

1. Purpose/Concept: To evaluate the quality and quantity of care as it is delivered by the APP, the purpose being to identify the extent for consistency to establish standards of practice.

   a. To provide evidence to utilize as the basis of recommendations for new and altered policies and procedures to improve care.
   b. To identify those areas where practice patterns indicate more knowledge is needed.

2. The primary or back-up supervising physician and the APP are continuously available to each other for consultation by direct communication or telecommunication.

3. Written protocols are agreed upon and maintained in the practice site. They are signed by both the primary physician and the APP.

4. Written protocols are reviewed at least yearly, and this review is signed by both the supervising physician and the APP.

5. The APP prescribes, orders, and implements drugs, devices, medical treatments, tests and procedures as outlined in the job description. (Job Description is available in the Division of Public Health Services Personnel Department.)

6. Client clinical records are audited quarterly and include all disciplines.

a. The purpose of the chart audit will be to:

- Ensure that the level of medical care specified by the policies, procedures, and protocols of the specified programs are being met.
- Discuss problems in clinical Adult Health Programs and make recommendations to correct deficiencies found, and other improvements.

b. The chart selection will be based on a random sampling of the program and quarter in review. The Division of Public Health audit forms will be used.

c. The results of the audit will be tabulated and recorded in minutes. Information discussed within the report will have the client medical record number, rather than any other identifying information.

d. All members of the program team will be informed of the results of the audit. The strengths and weaknesses will be identified and summarized along with a corrective plan of action.

K. Quality Improvement Standards – APP

1. Purpose: To provide an on-going review and to evaluate the quality of the care provided for one or more frequently encountered clinical problems.

2. Methodology: A written evaluation plan developed by the Supervising Physician and APP shall include, but is not limited to the following common clinical problems:

a. Hypertension
b. Diabetes
c. Arthritis
d. Hypercholesterolemia
e. Gynecological problems
f. COPD
g. Upper and lower respiratory infections
h. Diseases of the skin (rashes)
i. Gastrointestinal problems
j. Acute injuries
k. Sexually transmitted diseases
l. Genitourinary problems

3. Process: A scheduled meeting will be held every three to six months between the Supervising Physician and the APP. Documentation for each meeting shall contain, but is not limited to:

a. The most common clinical problems encountered

b. Current treatment and interventions
c. A plan, if needed, for improving outcomes within an identified time frame
d. Signatures and dates of all attendees
e. Copies of the scheduled meetings will be retained by both the APP and physician and be available for review by members or agents of either board for the previous five calendar years.

L. Continuing Education Standards

1. (PA) Rule 21 NCAC 325.0216. states that the Physician Assistant shall complete 50 hours of continuing medical education (CME) every 2 years.

2. (NP) Rule 21 NCAC 32M.0107 states that the Nurse Practitioner shall earn 50 contact hours of continuing education each year.

At least 20 hours of the required 50 hours must be those hours for which approval has been granted by the American Nurses Credentialing Center (ANCC) or Accreditation Council on Continuing Medical Education (ACCME) or other national credentialing bodies or practice relevant courses in an institution of higher learning.

APPs may choose to obtain formal continuing education credits from the above bodies for the full 50 hours, or they must choose to complete the following activities for all or any part of the 30 hours that do not have to meet the formal criteria.

a. Five (5) hours – Clinical Presentations – Designing, developing and conducting an educational presentation(s) for health professionals totaling a minimum of 5 contact hours.
b. Preceptor hours – with validation from educational program – up to 30 hours.
c. Five (5) hours – author on a journal article or book chapter published during renewal year.
d. Fifteen (15) hours – primary or secondary author of a book published during renewal year.
e. Ten (10) hours – Completion of an Institutional Review Board (IRB) approved research project related to your certification specialty.
f. Five (5) hours – Professional volunteer service during renewal year with an international, national, state or local health care related organization in which your NP or certification specialty expertise is required. Examples of

accepted volunteer activities include board of directors, committees, editorial boards, review boards or task forces.

3. Documentation must be maintained by the APP at each practice site and made available upon request by either board.

   APPs will document all continuing education hours, as in person contacts with the medical consultant, on the Advanced Practice Provider log.

M. Medical Resource List

If the client is unable to purchase the prescribed medications or if the medical provider is unable to provide the client with sample medication, a list of resources is available in Adult Primary Care.

N. The Adult Health Programs will distribute client satisfaction surveys.

1. Client Satisfaction Surveys are distributed monthly within the Adult Health Programs.

2. Attempts will be made to seek every client's participation in completing the electronic survey.

3. The results will be compiled monthly and a report of the findings will be generated among staff. Areas for improvement will be addressed. The Quality Improvement Council reviews results.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COLPOSCOPY PROTOCOLS

DATE DEVELOPED: 3/99
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/18; 6/24

I. POLICY:

The Division of Public Health Services Advanced Practice Providers (APPs) follow the **ASCCP-American Society for Colposcopy and Cervical Pathology guidelines for management of abnormal PAP screening results.** Colposcopy will be made available to eligible clients needing this service and will be performed at the Division of Public Health Services as an Adult Primary Care service per Adult Primary Care billing guidelines. Colposcopy is performed by a **trained** APP or physician.

II. PURPOSE:

Colposcopy is a diagnostic procedure performed **to examine the cervix, vagina and vulva. Colposcopy may be used to check for cancer of the cervix, vagina and vulva and changes that may lead to cancer. Colposcopy is performed to aid in evaluation and management of abnormal PAP screening test results.**

III. GUIDELINES:

A. Eligibility

Any client 21 years of age or older, meeting the residency requirements, may receive colposcopy through the Division of Public Health Services. Clients may be charged according to a sliding fee scale set by the Fee and Eligibility Policy (B-1).

B. Indications for Colposcopy

The need for colposcopy will be based on algorithms provided by the American Society for Colposcopy and Cervical Pathology (ASCCP)**, APP clinical judgement** or guidance from the consulting physician for clients with a complex medical history.

C. Objectives of the Colposcopic Exam

1. Visualize the cervix and surrounding tissue
2. Identify squamocolumnar junction (SCJ) and transformation zone completely (when possible)

3. Assess suspected lesions for severity of disease
4. Target the most severe areas for biopsy
5. Determine the adequacy of the examination
6. Obtain representative biopsy sample and endocervical curettage (ECC) as indicated
7. Formulate a colposcopic impression
8. Correlate laboratory results and impression for final diagnosis
9. Determine management and follow-up plans

D. Management and Follow-Up

Management of pathology will be based on management guidelines per ASCCP. Additionally, the APP may **use clinical judgement or** consult the consulting OBGYN physician for the following conditions:

1. Discordant pap/biopsy results
2. High grade lesion on pap or biopsy
3. Complex abnormal cytology history

Clients who require follow-up Pap smears will be followed through the Division of Public Health Services' Adult Health Program and/or in partnership with the Family Planning Clinic. Clients will be advised of findings and recommendations for follow-up via phone call, follow-up appointment, or letter. After three unsuccessful attempts to contact client, a certified letter will be mailed. Designated staff will utilize a tickler system for tracking any needed follow-up according to the schedule recommended by the clinician, and a reminder letter will be sent to the client when the repeat Pap smears are due. (See Family Planning Policy-1 pertaining to abnormal pap follow-up guidelines.)

E. Clients who are recommended for treatment beyond the scope of the health department APP will be referred to a Physician. Clients may be referred back to the Division of Public Health Services for follow-up after treatment recommended by consulting physicians.

F. It is important to realize that guidelines should never substitute for clinical judgment. Clinical judgment should always be used when applying a guideline to an individual patient.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COLPOSCOPE EQUIPMENT MAINTENANCE

DATE DEVELOPED: 8/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/21; 6/22; 6/24

I. POLICY:

The colposcope, a special microscope, at the Division of Public Health Services will be serviced annually and as needed by the Southern Microscope Company.

II. PURPOSE:

Maintenance and proper functioning of the colposcope. The colposcope is **maintained for** diagnostic evaluation of abnormal pap smears for **eligible Rockingham County female clients. Colposcopy service is provided in the** Adult Primary Care Program.

III. GUIDELINES:

A. Routine Maintenance of Equipment:

1. The Advanced Practice Provider (APP) will check the colposcope prior to usage.

2. The colposcopes for the Adult Primary Care Program will be stored in **supply** room 18 and covered with plastic covers.

B. Supplies for Colposcope Equipment:

1. Supplies for colposcope equipment may be purchased from Cooper Surgical Company (1-800-243-2974).

2. Bulbs for the colposcope may be purchased from Southern Microscope Company (1-800-227-7276).

C. Servicing of Colposcope

Southern Microscope Company provides annual servicing of colposcope equipment and may be called as needed for other service needs of the colposcope (1-800-227-7276).

D. Cleaning of Colposcope Equipment

The colposcope is cleaned with a cloth or paper towel sprayed with a germicidal disinfectant after usage between clients.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MEDICATION ASSISTED TREATMENT (MAT)

DATE DEVELOPED: 4/8/2024
REVIEWED: 6/24
REVISED:

I. POLICY:

This policy is to highlight how Rockingham County Division of Public Health will provide chronic disease management for individuals with opioid use disorder using buprenorphine/naloxone or Buprenorphine as medically indicated.

II. PURPOSE:

The purpose of this policy is to reduce the morbidity and mortality rates through early detection, treatment, and education for individuals identified with opioid use disorder.

III. GUIDELINES:

The following procedures will be followed:

A. Screening: All Rockingham County Health Department patients 18 years of age or older should be screened for substance use disorder by asking the substances they use and frequency of use.

- Patients identified as substance users will be further screened for substance use using the DAST (Drug Abuse Screening Tool).

B. Referral for Medication Assisted Treatment for Opioid Use Disorder:

- Patients who screen positive for substance use disorder via DAST will be given an option of a referral after discussion of the findings. Referral options include a list of local mental health resources, and or referral for direct treatment to our internal MAT (Medication Assisted Treatment)/Medication for Opioid Use Disorder (MOUD) clinic.

C. Medication Assisted Treatment with Buprenorphine or Buprenorphine/ Naloxone:

1. Prior to Initial Appointment

    a. When possible all patients should complete the initial intake over the phone with the counselor or provider.
    b. Staff should review the program in detail so the patient knows what to expect from their first appointment on.

2. Initial Appointment

    This will be a long appointment that will include the following:

    - Completing all necessary consents;
    - Completing the MAT/MOUD related patient forms including the treatment agreement;
    - History and Physical exam as appropriate;
    - A comprehensive drug screen.
    - Check the patients prescription history on PMP Aware (NC Controlled Substance Registry);
    - Referral for physical and mental health needs when appropriate;
    - Referrals for social determinants of health as needed;
    - Ensure all patients have Naloxone (RCDPH Pharmacist can supply if needed);
    - Ensure all patients have a safe place to secure and lock meds. If they do not, RCDPH can supply med boxes if available;
    - Educate patient on how to start and take Buprenorphine or Buprenorphine/Naloxone;
    - Prescriptions written as indicated; and
    - Follow-up visit per provider's preference.

D. Subsequent office visits (weekly, bi-weekly, monthly, bi-monthly):

1. Provider will review the Patients PMP Aware
2. Complete urine drug screen as indicated
3. Pill/Film Count
4. Evaluate SOWS (Subjective Opiate Withdrawal Scale/Cows (Clinical Opiate Withdrawal Scale)
5. Ensure the patient has Naloxone Available (RCDPH Pharmacist can supply if needed)
6. Ensure patient has a secure place to store meds. If they do not RCDPH can supply med boxes if available.
7. The provider will order labs as deemed appropriate which include , LFT, Hep C screening , Hepatitis B screening, Hepatitis A screening, HIV, syphillis, BMP and pregnancy test for females.
8. Prescription written as indicated
9. Follow-up visits per provider's preference.

E. Random Pill/Film Counts and Urine Drug Screens (clinical time is billable - 99211):

1. As ordered by provider
2. The patient will have 24 hours to come in for UDS/Pill count. If they do not come within 24 hours, they will be considered an abnormal count and or UDS.
3. Provider/Counselor will talk to the patient prior to urine drug screen to see if their will be anything unexpected in their drug screen.
4. Findings will be evaluated by the provider.

F. Extended Leave Policy:

1. If patient will be out of the area for more than 30 days and is in good standing, the provider may choose to refill their Buprenorphine or Buprenorphine Naloxone without an office visit.
2. If a patient is out of the area more than 90 days they will need to find a different prescriber.

G. Patients with Pain:

1. Acute Pain

- In the event of illness or injury a patient should be first treated with a non-opioid analgesic.
- If buprenorphine/naloxone is being dosed once a day the patient should split the dose into three times per day while maintaining the same dosage.
- If the patient's pain is not relived with a non-opioid analgesic and split dosing, a short acting opioid may be required. This will require the patient to be seen at an external provider other than the RCDPH due to we do not prescribe Opioid products in our clinics per our Medical Directors guidance.

2. Chronic Pain

- The patient will be referred out

H. Dismissal Policy:

At the provider's discretion, patients may be dismissed from the clinic with a referral to a higher level of care.

I. Relapse Policy (provider discretion):

1. Increase frequency of visits
2. Refer to a higher level of care

J. Billing:

1. All patient visits will be billed under adult health visits under the MAT/MOUD program
2. All clinical services provided to the patient during their visit will be billed according to the RCDPH billing policy.
3. In the event RCDPH has uninsured patients then OPIOD funding may be utilized for payment of services.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NALOXONE ADMINISTRATION

DATE DEVELOPED: 05/22/2024
REVIEWED:
REVISED:

I. POLICY:

This policy establishes guidelines for all county employees to administer naloxone, contingent upon successful completion of the Naloxone Administration Certification Training provided by the Public Health Department. Naloxone, also known as Narcan, is a medication used to reverse opioid overdoses and can be administered through various routes such as intramuscular injection, intranasal spray, or auto-injector.

II. PURPOSE:

To promote a safer and more effective response to opioid overdose emergencies within the county.

III. GUIDELINES:

A. All county employees are eligible to participate in the Naloxone Administration Certification Training program.

B. Participation in the training program is voluntary but strongly encouraged for employees who may encounter opioid overdose situations in the course of their duties.

C. The Public Health Department shall provide comprehensive training sessions on naloxone administration.

D. Training sessions will cover topics such as recognizing opioid overdose symptoms, proper administration techniques, potential risks and side effects, and post-administration procedures.

E. Employees must successfully complete the training program to be certified for naloxone administration.

F. Upon successful completion of the training program, employees will receive a certification of naloxone administration.

G. Certification will be valid for two years, after which employees may be required to undergo refresher training to maintain certification status.

H. Certified employees may carry naloxone kits during work hours and utilize them in emergency situations where opioid overdose is suspected.

I. Naloxone administration should follow established protocols and guidelines provided during the training sessions. (All RCDPH RN/LPN personnel will follow Standing Order AP-5.)

J. Employees must report any naloxone administration incidents to their immediate supervisor and complete any necessary documentation as per departmental procedures.

K. Employees who administer naloxone in good faith during an emergency overdose situation will be protected from civil liability under applicable state laws: NC Good Samaritan/Naloxone Access Law § 90-96.2. Drug-related overdose treatment; limited immunity.

L. The Public Health Department shall maintain records of all employees who have completed the naloxone administration training and received certification.

M. Amendments:

a. This policy may be amended or revised as necessary to accommodate changes in regulations, best practices, or emerging trends related to naloxone administration and opioid overdose response.

dw/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TELEHEALTH SERVICES

DATE DEVELOPED: 6/4/2024
REVIEWED:
REVISED:

I. POLICY:

The Rockingham County Division of Public Health (RCDPH) will promote a quality telehealth service for the patient and provider according to the NC Division of Health Benefits (DHB) NC Medicaid Clinical Coverage Policy 1H, *Telehealth, Virtual Communications, and Remote Patient Monitor* at https://medicaid.ncdhhs.gov/1h-telehealth-virtual-communications-and-remote-patient-monitoring

Definitions:

1. Telehealth: Telehealth is the use of two-way real-time interactive audio and video to provide and support health care when participants are in different physical locations.

2. Remote Patient Monitoring: Remote Patient Monitoring is the use of digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient monitoring enables providers to collect and analyze information such as vital signs (blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types of remote patient monitoring addressed within this policy:

    a. Self-Measured and Reported Monitoring – When a beneficiary uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation.
    b. Remote Physiologic Monitoring – When a beneficiary's physiologic data is wirelessly synced from a beneficiary's digital device where it can be evaluated immediately or at a later time by a provider.

3. Virtual Patient Communication: Virtual Patient Communication is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a beneficiary or a provider and another provider. Covered virtual patient communication services include telephone conversations (audio only); virtual portal communications (secure messaging); and store and forward (e.g., transfer data from beneficiary using camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).

Originating Site - The site where the patient is located.

Distant Site - The site where the provider is located. Providers must ensure that patient privacy is protected (e.g., taking calls from private, secure spaces, using headsets).

Established Patient – An Established Patient refers to a beneficiary who has received any professional services (including services via telehealth) from the provider or another provider of the same specialty who belongs to the same group practice within the past three years. Since telehealth services are considered professional services, a beneficiary and provider relationship may be established via telehealth.

New Patient – A New Patient refers to a beneficiary who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years.

II. PURPOSE:

To ensure adherence to all applicable laws, rules, and regulations while ensuring patient access and reducing barriers to healthcare and/or medical management services using telehealth services. By implementing these procedures, RCDPH will provide telehealth services to patients with Medicaid regardless of where the patient or provider is located. Telehealth services are provided to better enable the delivery of remote care to patients.

Responsible Staff:

All Advanced Practice Providers (APP) and/or Physicians. Responsibilities may include use of interpreters, registered nurses, information technology (IT) staff, and administrative and ancillary staff.

III. GUIDELINES:

A. Scope of Service

1. Services - the following services will be available using telehealth modalities:

    a. Medical services via telehealth will not deviate from standards of care applicable to in-person assessment, diagnosis, and treatment plan.
    b. The telehealth medical services by the Physician and APP may be an adjunct to periodic in-person contact or it may be the only contact by the Physician or APP.

c. Telephonic visits (audio) can only be provided to established patients.

2. Contraindications for Use of Telehealth Services - The Physician or APP should request an in-person visit if any of the following occur:

a. The patient's condition does not lend itself to a telehealth visit as deemed by the provider;
b. There is a lack of equipment;
c. Equipment failure; or
d. Inadequate visual or sound quality.

B. **Environmental Security**

1. The privacy and confidentiality of the telehealth medical services will be maintained by ensuring that the locations of the providers are secure. The services will be provided in a controlled environment (closed doors) where there is a reasonable expectation of absence from intrusion by individuals not involved in the patient's direct care.

2. Whenever possible, the presence of a non-clinical staff during medical services should be avoided.

3. The physical environments of the distant site provider should ensure that the patient's protected health information remains confidential.

C. **Patient Health Information, Privacy, Confidentiality, and Security**

1. Responsible staff of telehealth services must follow the agency's policies and procedures for HIPAA and confidentiality.

2. All staff must follow the agency's policy and procedures for release of information.

3. All telemedicine and telehealth services will be provided with HIPAA-complaint technology unless otherwise allowed by federal and state policies.

4. Informed Consent:

a. RCDPH will follow the agency's policy on informed consent to include minor's consent laws.
b. Informed consent for telehealth services will be obtained from the patient or patient's legal guardian prior to the service and documented in the EHR.

c. The patient and/or patient's legal guardian will be made aware of the potential risks and consequences as well as likely benefits of the telehealth medical services, and will be given the option of not participating. Patients and patient's legal guardian will be informed of services and services will not be withheld if the telehealth medical encounter is refused, although such care will depend on availability of alternative resources.

D. **Required Documentation**

All documentation of the telehealth medical services will be documented in accordance with applicable standards, guidelines, by-laws, rules and regulations.

1. All patient health information and services provided through telehealth will be documented in the EHR per policy and programmatic requirements.

2. Informed consent for the telehealth medical services will be obtained from the patient and/or patient's legal guardian prior to the service and documented in the EHR per programmatic requirements.

3. The Physician or APP will document each visit with the patient including: date of service, start and stop time, additional people who participated in the visit at either site, and the location of the patient with enough detail to satisfy an audit.

4. Provider's notes will contain all components required in order to support the medical care provided and services billed per the RCDPH policies and procedures.

5. If there is lack of equipment or an equipment failure, in-person visit should be scheduled. If patient cannot be seen in-person that day, then they should be directed to another provider of choice.

6. The provider should note what modality was used to deliver the service rendered.

7. The provider should document and assign appropriate codes for reimbursement of services.

8. Providers shall ensure the availability for the appropriate follow-up care and maintain a complete health record that is available to all rendering providers.

E. **Training**

1. All staff members involved in telehealth services will have training on approved technology used for telehealth services. Training will be provided by RCDPH or by IT as needed.

2. Training must be provided initially and annually per workforce development and training policies.

F. **Equipment for Telehealth**

1. RCDPH is only responsible for their equipment and connectivity.

2. RCDPH IT support will be provided for telehealth services and will be compliant with agency IT policies and standards.

3. RCDPH will work to deliver clear audio/visual to allow for optimal communication and assessment of each patient served.

G. **Scheduling Appointments**

Scheduling appointments for telehealth medical services will be correlated if using Mobile Medical Unit (MMU) with the provider and MMU staff.

H. **Billing and Reimbursement**

Telehealth services will be billed per program guidelines and insurance reimbursement guidelines.

III. Legal Authority

1. HIPAA Health Insurance Portability Act 1996
2. G.S. 90-171.20 (7) & (8) - Nurse Practice Act
3. North Carolina General Statutes 90-21.5 and 90-21.4 Minors Consent Law
4. 45 CFR parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information; Final Rule
5. NC General Statute 143-518, Confidentiality of Patient Information
6. 42 CFR part 2 - Confidentiality of Substance Use Disorder Patient Records

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

BILLING, ACCOUNTS PAYABLE, ACCOUNTS RECEIVABLE POLICIES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: FEE, ELIGIBILITY REQUIREMENTS, AND BILLING

DATE DEVELOPED: **03/17**
REVIEWED: **6/17; 10/17; 2/18; 6/18; 7/10/18; 8/17/18; 6/19; 9/19; 6/20; 6/21; 12/21; 2/22; 6/22; 2/23; 6/23; 9/23; 6/24**
REVISED: **10/17; 2/18; 6/18; 7/10/18; 8/17/18; 6/19; 9/19; 6/20; 6/21; 12/21; 2/22; 6/22; 2/23; 6/23; 9/23; 6/24**

I. POLICY:

Public health services are increasingly costly to provide. The Health Department serves the public interest best by assuring that all legally required public health services are furnished for all citizens and does not discriminate against any client based on religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies or marital status and then providing as many recommended and public health services as it can for those citizens with greatest need.

Rockingham County Department of Health and Human Services, Division of Public Health Services provides services without regard to religion, race, national origin, creed, gender, parity, marital status, age or contraceptive preference.

Fees are a means to help distribute services to citizens of the county and help finance and extend public health resources, as government funding cannot support the full cost of providing all requested services in addition to required services. Fees are considered appropriate, in the sense that while the entire population benefits from the availability of subsidized public health services for those in need, it is the actual users of such services who gain benefits for themselves.

Fees for Health Department services are authorized under North Carolina 130A-39 (g), provided that 1) they are in accordance with a plan recommended by the Health Director and approved by the Board of Health and the County Commissioners, and 2) they are not otherwise prohibited by law. Fees are based on the cost of providing the service. Minimum administrative or other flat rate fees applied without discrimination.

Fees Collected (generated through reimbursement) will be maintained in an identifiable line item in the Health Department and the County Finance Office.

Rockingham County Division of Public Health has the right to require "proof of income" when determining eligibility for all programs, with the exception of Communicable Disease programs and state supplied Immunizations.

II. PURPOSE:

To establish guidelines for client admission, establish fee rates for services, to verify income, release of information to insurance carriers for revenue source,

inform clients of their financial responsibilities, and to collect payments for services rendered to the Division of Public Health Services with medical and dental clinics. No client will be denied services due to inability to pay.

III. GUIDELINES:

Identification & Proof of Address is considered "best practice" for each person presenting for services to establish identity & correct mailing address.

- Identification: either with a birth certificate or government issued ID with a picture such as driver's license, military ID, passport, visa, green card, etc. (photocopy must be in black & white). A local health department may not require a client to present identification that includes a picture of the client for at least immunization, pregnancy prevention, sexually transmitted disease and communicable disease services (CAFY23 Rockingham, I.A.6.). However, you may take a photograph of the client (with their permission) for internal use only.
- Proof of Address: either with a utility bill or **internet** bill, etc.

All clients will sign and date a "Terms and Conditions" form. *(See attached)*

IV. DETERMING GROSS INCOME:

Gross income is the total of all cash income before deductions for income taxes, employee's social security taxes, insurance premiums, bonds, etc. For self-employed applicants this means net income after business expenses.

Source of Income

1. Alimony
2. Bank Statement
3. Cash (any cash earnings, contributions received)
4. Check Stub (includes regular wages, overtime, etc.)
5. Child Support (cannot consider as income for Family Planning)
6. Client Statement
7. Disability
8. Dividends
9. Employment Security Commission
10. Income Tax Return (annual, not quarterly)
11. Letter of Verification from Employer
12. Military Earnings Statement
13. NC Unemployment
14. Pensions
15. Social Security
16. SSI
17. Tips

Exceptions:

1. Effective 02/03/17 VA Disability Benefits (Disability compensation and pension payments for disabilities paid either to Veterans or their families, grants for homes, motor vehicles for Veterans who lost their sight or the use of their limbs, or benefits under a dependent-care assistance program.)
2. Payments to volunteers under Title I (VISTA) and Title II (RSVP, foster grandparents, and others) of the Domestic Volunteer Service Act of 1973
3. Payments received under the Job Training Partnership Act
4. Payments under the Low Income Energy Assistance Act
5. The value of assistance to children or families under the National School Lunch Act, the Child Nutrition Act of 1966 and the Food Stamp Act of 1977

Income verification/documentation will be required for all programs with the following exceptions:

- Immunizations
- County Employees
- Flu/Pneumonia Vaccine
- TB Skin Test
- TB Control
- Other Services

No client will be refused services when presenting for care based on lack of income documentation; however, each client will be billed at 100% until proof of income and family size is provided to the agency. The client will have 10 business days from date of service to present this documentation in order to adjust the previous 100% charge to the Sliding Fee Scale (SFS). If no documentation is produced within 10 business days then the charge stands at 100% for that visit.

If a Family Planning client's income cannot be verified after reasonable attempts to do so, charges are to be based on the client's self-reported income.

Determining Family Size:

A family is defined as a group of related or non-related individuals who are living together as one economic unit. Individuals are considered members of a single family or economic unit when their production of income and consumption of goods are related. An economic unit must have its own source of income. Also, groups of individuals living in the same house with other individuals may be considered a separate economic unit if each group support only their unit. A pregnant woman is counted as two (including the unborn child) in determining family size.

Examples:

1. A foster child assigned by DSS is a family of one with income considered to be paid to the foster parent for support of the child.
2. A student maintaining a separate residence and receiving most of her/his support from her/his parents or guardians may be counted as a dependent of the family. Self-supporting students maintaining a separate residence would be a separate economic unit.
3. An individual or family in an institution is considered a separate economic unit.
4. If a client requests "confidential services", regardless of age, the agency should consider them a family unit of one based on their income.
5. Interview questions for minors may include the following in the Family Planning or STD clinic:

    a. Ask the client if their parents are aware of their visit?
    b. Ask if "both" parents are aware of their visit, since sometimes one parent may be present with the client, however, the other parent may not be aware of the visit.
    c. Ask if you can send a bill to the home, to both parents.
    d. If the client states both parents are aware and it is not a confidential visit, you should treat as such.

Computation of Income:

(Regular Income Formula)

The client's income will be determined by the following:

Income will be based on a twelve (12) month period. If the client is working the day they present for a service, income will be calculated weekly (52), bi-weekly (26), monthly (12) or annually, depending on the documentation obtained. If the client is unemployed the day they present for their service, their "employment only" income will be calculated at zero (0), however the client should be required to provide "their mechanism", in regards to their paying for food, clothing, shelter, utility bills, etc. Refer to "sources of income" counted and apply all sources, as appropriate. "Regular contributions received from other sources outside of the home" is most often considered one of those sources. If the client is receiving unemployment or other "sources" of income, as designated above, all of those sources should be counted.

Unemployment or Irregular Income Formula:

- Six months' formula
- Wage earners unemployed at time of application
- Unemployed any time during previous 12 months
- Example: Unemployed today
- Income determined six months' back

- Income determined six months' forward
- Total = 12 months of income

A copy of the Financial Eligibility Determination should be maintained for future reference. The number in the household, annual gross income and percentage of pay should be reflected on the financial documentation. The documentation should be signed and dated by the interviewer and client. Use of electronic signatures is acceptable.

Income is re-assessed annually unless there has been a change in financial status or the SFS is updated resulting in a change to patient responsibility. Following the initial financial eligibility determination, the client will be asked at each visit if there has been a change in their financial status. Income will always be based on the "actual date" of service. If there has been a change or it is time for their annual review the income determination process should take place. Client fees are assessed according to the rules and regulations of each program and the recommended Program's Federal Poverty Level Scale (SFS) will be used to determine fees. All third-party providers are billed where applicable. Both income and family size are required to be assessed at every visit regardless of health insurance status. These are required for FPAR reporting and must be submitted through the LHD-HSA system for each family planning encounter.

Clients presenting with third party health insurance coverage where copayments are required shall be subject to collection of the required copayment at the time of service. For Family Planning (Title X) clients the copay may not exceed the amount they would have paid for services based on SFS.

Income information reported during the financial eligibility screening for one program can be used through other programs offered in the agency, rather than to re-verify income or rely solely on the client's self-report.

The SFS is subject to change, and the most current SFS is in effect at the time of service and must be utilized and adjusted appropriately even after the annually signed declaration that was agreed upon prior to the new SFS.

V. ELIGIBILITY:

A. ADULT HEALTH

Eligibility: Rockingham County resident; 21 years and older; SFS; Insurance; Medicaid

Self-Pay and 3rd Party Insurance clients will be based on the SFS at 20% or higher depending on total household income plus the cost of outside labs (labs do not slide for self-pay clients). Clients who are at 100% to 125% poverty level will pay at 20% of the established fees. Clients who are at 150% poverty level will pay at 40%, clients at 175% poverty level will pay 60%, clients at 199% poverty level will pay 80% and clients at or above 200% poverty level will pay the full amount.

If the client fails to bring household income on the day of service, they will be considered at 100% pay at the time of service.

The SFS utilized for clients will reflect 100%-200%.

B. **CHILD HEALTH**

Eligibility: Rockingham County resident; birth through 20 years; SFS; Insurance; Medicaid

The SFS utilized for clients will reflect 100%-200%.

C. **COMMUNICABLE DISEASE CONTROL**

Eligibility: No residency requirements. Medicaid and Insurance can be billed, no fees charged to the client for these services as stated in Program Rules.

Rockingham County DHHS will bill the actual drug purchased price when requesting reimbursement through Medicaid for all 340B drugs.

D. **DENTAL HEALTH**

Eligibility: Contracted Insurance; Medicaid; Self-Pay

Self-Pay

Self-Pay clients will be based on the SFS at 60% or higher depending on total household income. Clients who are at 100% to 175% poverty level will pay at 60% of the established fees. Clients who are at 199% poverty level will pay at 80% and those at or above 200% poverty level will pay the full amount. Due to the extent of procedure period involving multiple appointments, lab fees and cost of materials, the following procedures will be excluded from the SFS: D2740, D2750, D2790, D2792, D6740, D6750, D6790, D6792, D7205, D6245, D6210, D6212, D6240, D9944, D9972, and D9972R. If for any reason the client does not pay the balance in full at the time of service, the client will be required to pay the balance before receiving additional services. If the client fails to bring household income on the day of service they will be considered at 100% pay at the time of service. Crowns and bridges will be considered at a 10% discount for self-pay clients.

County Employees seen in the dental clinic are expected to pay 25% of their responsibility at the time of service and the remaining balance within 6 months from the date of service.

Clients with a balance of less than $50 are billed quarterly. Clients with a balance of $50 or more are billed monthly.

When available, grant/donation funds will pay for school-age children who have no insurance and no income. They must be referred by the health department practitioners and/or school nurse to be seen.

The SFS utilized for clients will reflect 100%-200%.

E. **MOBILE DENTAL UNIT**

Eligibility: Medicaid

The Mobile Dental Unit travels to elementary, middle and high schools in Rockingham County to provide on-site dental care to children who receive Medicaid.

When available, grant/donation funds will pay for school-age children who have no insurance and no income. They must be referred by the health department practitioners and/or school nurse to be seen.

F. **FAMILY PLANNING**

Eligibility: Women of childbearing age regardless of residency; SFS, Medicaid, Insurance

The following shall apply to Family Planning clients:

1. If a client is considered to be "confidential" this will be documented on the Financial Eligibility form.
2. The SFS utilized for clients will reflect 101%-250% and is updated annually by the federal government.
3. The use of NC Debt Setoff is acceptable for collecting past due amounts for Family Planning clients except where doing so may jeopardize patient confidentiality.
4. Bills/receipts given to clients at the time of service show total charges, as well as any allowable discounts.
5. Where a third party is responsible, bills are submitted to that party. Bills to third parties show total charges, without discounts, unless there is a contracted reimbursement rate that must be billed per the third party agreement.
6. Bills for clients requesting confidential services are not sent to the insurance carriers when an EOB may compromise client confidentiality.
7. Rockingham County DHHS will bill the actual drug purchased price when requesting reimbursement through Medicaid for all 340B drugs.
8. If a Family Planning client refuses to provide a verbal declaration of income and income cannot be verified through access to enrollment in another program within the agency, then the client may be charged 100% of the cost of services after informing the client that

failure to declare income will result in the client owing 100% of the fee.

9. Family Planning clients will pay the lesser of the copay and additional fees or where they fall on the SFS as required by Title X.
10. **All emergency contraceptive drugs will be priced at the acquisition cost and paid for at the time of service after the SFS has been applied.**

G. IMMUNIZATIONS

Eligibility: No residency requirements. Medicaid and Insurance can be billed. Self-Pay clients (19 years and older) must pay at the time of service.

Clients with Medicare or third party health insurance who receive a flu and/or COVID-19 vaccine must sign a waiver regarding non-payment from insurance if vaccine(s) is not covered. *(See waiver form attached).*

H. **MATERNAL HEALTH**

Eligibility: Rockingham County residents. SFS; Medicaid or potentially Medicaid eligible, Insurance

The SFS utilized for clients will reflect 101%-250%.

I. **MD NIGHT CLINIC OFFICE VISITS ONLY**

Clients who are brought back to the clinic for a consultation with the Medical Director will be coded as a 99241 (minor level office consultation) indeterminate of the length of visit complexity. The fee for the 99241 office consultation will be $0. However, if any bloodwork is sent to the outside laboratory during the MD night clinic visit, the client will be responsible for 100% of the cost associated with the lab work, or their insurance will be billed.

J. **MEDICATION FOR OPIOID USE DISORDER (MOUD)**

Eligibility: No residency requirements. Medicaid and Insurance can be billed. Self-pay clients at 60% SFS.

Insurance will be billed at no cost to the patient. Self-pay patients will not be charged for any expenses. MOUD funds will be utilized to pay for all charges including all outside labs. Lab payments will be applied to Adult Health clinic.

K. **PEDIATRIC PRIMARY CARE**

Eligibility: Rockingham County resident; birth through 20 years; SFS; insurance; Medicaid

The SFS utilized for clients will reflect 100%-200%.

L. **OTHER SERVICES**

Only those services approved by the Health of Local Technical Assistance & Training Branch may be identified as Other Services (e.g. pregnancy test; TB skin test; blood testing for work; etc.)

Eligibility: No residency requirements. No SFS applies. Fees vary. Payment is expected at the time of service. Medicaid and Insurance will not be filed.

M. **LABS:**

Self-Pay

Adult Health program is responsible for outside labs. No SFS applies.

STD program is never charged for outside labs unless the client requests a specific lab then no SFS will apply.

Outside lab services will be applied to the SFS for Child Health, Pediatric Primary Care and Family Planning/Women's Preventive Health Programs.

Any additional labs ordered by the provider will be charged to the client based on current vendor pricing. Payments are to be collected at the time of service.

N. Women's, Infant's and Children's Nutrition (WIC) - Supplemental nutrition and education program to provide specific nutritional foods and education services to improve the health status of target groups.

Eligibility:

WIC is available to pregnant, breastfeeding, and postpartum women as well as infants and children up to age 5. The following criteria must also be met: 1) be a resident of North Carolina; 2) be at medical and/or nutritional risk; 3) have a family income less than 185% of the US Federal Poverty Level; Medicaid, AFDC, or food stamps automatically meet the income eligibility requirement.

Medical Nutrition Services provided by a RD. Lactation Services are provided by an IBCLC.

VI. BILLING & REVENUE:

In accordance with G.S. 130-A-39(g), which allows local health departments to implement a fee for services rendered the Rockingham County Health and Human Services, Division of Public Health, with the approval of the Rockingham County Board of Health and Human Services and the Rockingham County Commissioners will implement specific fees for services and seek reimbursement. Specific methods used in seeking reimbursement will be through third-party coverage,

including Medicaid, Medicare, private insurance, and individual client pay. The agency will adhere to billing procedures as specified by Program/State regulations in seeking reimbursement for services provided.

- SFSs are used in all state/federal funded programs that generate fees.
- Deductibles and coinsurance amounts are transferred to the client on a SFS basis.
- SFS is not applied to co-payments except in Family Planning services.
- Postdated checks are not accepted by the health department.

Fee Collections:

1. Payment is due and expected at the time services are rendered. However, if a client has an account balance and fails to make monthly payments on the account, he/she will be considered as "non-compliant". **The Agency has the right to discharge the client per Client Dismissal Policy, NUR-17** (with the exception of those programs receiving Title V and Title X monies).
2. As a courtesy, Rockingham County employees may be seen in the dental and/or medical clinics. However, the employee will be responsible for any balance after insurance and is expected to make monthly payments on the account to keep it in good standing. If the employee's account becomes delinquent, he/she will be referred to their private physician/dentist until the account is in good standing.

   (The employee may still receive their annual flu/COVID vaccine and any services required by staff development.)

3. Management Support Staff will request a payment plan for all clients who have balances of a $150 or more. *(See Payment Agreement attached)*.
4. Monthly statements will be mailed to the client/responsible party as long as confidentiality is not jeopardized. Clients with a balance of less than $50 are billed quarterly.
5. The Health Director or designee in consultation with staff is authorized to adjust the charge for a client who is unable to pay due to good cause. This waiver will be handled on a case-by-case basis in consultation with appropriate staff.
6. All client payments made in person or by mail for the medical and/or dental clinic are posted the date they are received to the oldest balance owed. A receipt is given to the client for in person payments.
7. All payments are forwarded to the Accounting Assistant, Accounting Specialist, or designee by 4:00 p.m. each day. All monies collected between 4:00 p.m. and 5:00 p.m. are deposited the morning of the next business day.
8. Industry Bills are generated and mailed every 30 days.
9. Rockingham County DHHS will utilize the Worthless Check Program through the District Attorney's office for any returned checks for

Environmental Health and the medical and dental clinics. (*See Letter 1 and Certified Mail letter attached*)

10. Rockingham County DHHS medical clinic will file insurance for all individuals with coverage and have out-of-network benefits with the exception of HMO polices & Medicare. We only file Medicare insurance for flu, pneumonia, and COVID vaccines. HMO policies require clients to seek care from the primary care provider.
11. Rockingham County DHHS dental clinic will file insurance for all individuals with coverage for in-network benefits. Out-of-network insurance is at the discretion of the dentist.
12. Medicaid requires a $4.00 copayment for clients 21 years of age and older for Adult Health and Dental Health.
13. The Billing Office is responsible for handling all contract disallowed functions to credit and/or debit the client's ledger account.
14. The Billing Office is responsible for handling all Bankruptcy notices (filing and discharge) and then credits the client's ledger account.
15. The Billing Office is responsible for handling all notice of deceased and then credits the client's ledger account and/or file with NC Debt Setoff for 2 years.
16. All write-offs for client accounts, with the exception of contract disallowed amounts, must be approved in writing by the Director of Nursing, Health Director.
17. The Billing Office will issue refunds to clients who have a credit balance of $10 or more. Anything under $10 will be left on the client's ledger for future visits. If the client cannot be located for funds of $50 or more, the funds will be sent to the NC Department of State Treasurer Unclaimed Property Division. *(See House Bill 294 attached.)* Refunds are approved by the Health Director, Director of Nursing, or Dentist.
18. Rockingham County DHHS does accept assignment for most insurance carriers, however, clients will be held responsible for all disallowed contractual adjustments for insurances we are not in-network with or not under contract with due to low reimbursements.
19. Medications from the Pharmacy are paid for at the time of service; it is a separate payment from clinical services. If no payment is received on the clinical services within 120 days, the balance owed will be sent to NC Debt Setoff per the guidelines.
20. The Billing Office will handle all delinquent accounts from AR Report including denied insurance claims and corrections for re-bill weekly.
21. Effective 3/1/18, Rockingham County will charge a $25.00 return check fee.
22. Rockingham County Department of Health and Human Services, Division of Public Health now accepts credit card payments from Visa, MasterCard, Discover, and Diners Club International for medical and dental services. Payments are taken by designated staff in both clinics through Paymentus, a secure third party processing vendor and can be made in person or over the

phone. There is a 2.95% processing fee for all transactions made through the Dental Clinic. This fee must be quoted to the client to gain consent before processing the payment. There is no service fee for medical services. Please refer to the Credit Card Policy provided by Rockingham County Information Technology for additional information.

23. **Financial hardship will require an application to be filled out and submitted back to the health department for review. It will be discussed one-on-one with the Health Director or designee in consultation with the patient. A charge-off adjustment may be authorized with proof of good cause.**
24. **Refugees will follow the guidelines for self-pay clients for medical and dental services. (Refer all refugees to DSS for possible medical coverage/assistance.)**

Billing Corrections:

It is the policy of the Division of Public Health Services to correct accounts that are determined to be incorrectly billed. The most common incorrectly billed accounts will be identified during quarterly client record reviews/audits. Payers will be refunded/recouped for codes billed too high for the service provided and rebills will be submitted for codes billed too low for the service provided.

Determination and Resubmission of Incorrectly Billed Accounts:

1. Staff Development Coordinator will complete a quarterly chart and billing audit findings summary.
2. Staff Development Coordinator will take reviewed charts notated to have incorrectly billed encounters to the Director of Nursing.
3. The Director of Nursing will take the charts to the provider who performed the services for their review and determination of the correctness of coding.
4. If it is determined that an encounter was not billed correctly, the provider will have the Staff Development Coordinator document this determination on the quarterly summary.
5. If it is determined that an encounter was incorrectly billed, the Director of Nursing will deliver the appropriate information to the Billing Office for rebilling of the claim. An addendum to the EHR will be required to document purpose of rebill.

Donations:

Donations shall be accepted from any client for any program regardless of income status as long as they are truly voluntary. The client's account will not be reduced due to a donation. There shall be no "schedule of donations", bills for donations, or implied or overt coercion.

No Mail Policy for Confidential Clients:

1. When a client requests no mail, discussion of payment regarding outstanding debts shall occur at the time service is rendered.
2. If the client is unable to pay in full at the time service is rendered, a receipt will be given to the client reflecting the partial payment and the client will sign a confidential payment agreement. *(See Confidential Payment Agreement form attached)*
3. Medical record is flagged reflecting ---confidential services for today's visit. (EHR is flagged by practitioner for confidential services for today's visit; therefore no mail will be generated for this visit.) Management Support Staff will document in the comments field NO Mail for date of service and initial.
4. Every visit, client is reminded of the amount still owed.
5. No letters or correspondence concerning the confidential visit(s) will be mailed to the client.
6. Non confidential visit(s) will be mailed to the client monthly and sent to NC Debt Setoff for non-compliance.

Small Debt Write-Off

1. Accounts will be considered small debt write-offs when the balance is less than $3.00 and there has been no client payment activity on the account for more than 4 months.
2. Total amount of client small debt write-offs will be written off monthly by the Billing Office after the 4-month review of account.

Bad Debt Write-Off

1. **Medical** accounts will be considered uncollectible when there has been no client payment activity on the account for more than 12 months for balances less than $50.
2. **Dental accounts will be considered uncollectible when there has been no client payment activity on the account for more than 24 months for balances less than $50.**
3. Total amount of uncollectible balances will be approved by the Board of Health and Human Services and then written off by the Billing Office.
2. The client should never be informed that a debt has been written off.
3. If a client presents with payment for an account balance that has been written off, the payment shall be applied to the oldest balance currently showing on client record.

NC Debt Setoff

1. Effective 11/01/16, as authorized by NC General Statutes, Chapter 105A, Rockingham County Department of Health and Human Services Division of Public Health will utilize the NC Government Debt Setoff Program as an

avenue to enhance collections and reduce accounts receivable. Accounts delinquent after 120 days and $50 or greater will begin the Debt Setoff process and we can go back 3 years since last activity (statement/bill sent). Debts are collected through the client's NC State Taxes and/or Education Lottery winnings of $600 or greater.

2. The Financial Services Director for Rockingham County Government will serve as the Hearing Officer for all appeals.
3. Client letters are generated and mailed monthly for delinquent accounts.
4. Management Support Staff will still try to collect money owed even after balance has been sent to NC Debt Setoff until balance has been paid in full.
5. Confidential visits/patients are excluded from NC Debt Setoff.

Rev/di

ROCKINGHAM COUNTY
DIVISION OF PUBLIC HEALTH

Terms and Conditions for Our Clients / Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, I understand that:

- A copy of the *Rockingham County Division of Public Health Notice of Privacy Practices* is available.
- Upon penalties prescribed by law, I hereby affirm that to the best of my knowledge and belief, this income statement is true and correct.
- The information on the income statement may be checked by a state reviewer, and I agree to provide the financial records required to carry out the review.
- My income may be verified from my employer and/or other sources and I hereby authorize my employer and/or other sources to release such information for the purpose of verifying my income and resources.
- Fees for services may be reduced or waived upon verification of income eligibility. Also, I am aware that I am allowed 10 business days to submit my income verification.
- If I request a confidential visit, I am encouraged by the agency to make monthly payments on my bill.
- Payment for services is expected at the time of service. As a courtesy, my insurance may be billed.
- My signature will serve as legal "signature on file" for purposes of filing my insurance claims and payment of medical benefits for services rendered.
- As part of visit, some laboratory services are unable to complete in the clinic. I may receive a bill from the outside lab company and I will be responsible for the cost of any laboratory services.
- **If I am a minor under the age of 18 and have provided my parent's/guardian's income/insurance information for billing purposes, I agree to discuss all fees/insurance/billing and payment information with that parent or guardian.**
- I voluntarily give my consent for the Rockingham County Division of Public Health to use and/or disclose protected health information for purposes of treatment, payment, and health care operations, which may include information of a private and sensitive nature (such as STD's).
- I voluntarily consent for medical examinations, treatments and procedures which are deemed necessary in the opinion of my physician and health care providers, including HIV and laboratory testing.
- My medical information is strictly confidential and is protected by North Carolina General Statute 130A-143.
- My signature acknowledges that I have been given the opportunity to ask questions about this consent form and the opportunity to refuse services for myself or as the verified personal representative of the individual being seen.
- I may receive email, phone or text appointment reminders.
- This consent is valid for one year unless I revoke it in writing.

Can we bill your insurance should your diagnosis and/or treatment include STD services?

☐ Yes, I give permission ☐ No, I do not give permission

Your medical information from RCDHHS is shared with NC Health Information Exchange Authority (HIEA). If you wish to opt out of HIEA, please request the Opt Out Form from a staff member.

_____ _____ / _____ / _____
Signature of Client / Verified Personal Representative Date

_____ _____ / _____ / _____
Signature of Interviewer Date

CONDADO DE ROCKINGHAM
DIVISION DE SALUD PUBLICA

Términos y Condiciones para nuestros clientes / Acuse de Recibo de Aviso de Prácticas de Privacidad

Al firmar este formulario, entiendo que:

- Está disponible una copia del Aviso de prácticas de privacidad de la División de Salud Pública del Condado de Rockingham.
- Sobre las sanciones prescritas por la ley, por la presente afirmo que, a mi leal saber y entender, esta declaración de ingresos es verdadera y correcta.
- Un revisor estatal puede verificar la información en la declaración de ingresos y acepto proporcionar los registros financieros necesarios para llevar a cabo la revisión.
- Mis ingresos pueden ser verificados por mi empleador y/u otras fuentes y por la presente autorizo a mi empleador y/u otras fuentes a divulgar dicha información con el fin de verificar mis ingresos y recursos.
- Las tarifas por los servicios pueden reducirse o anularse tras la verificación de la elegibilidad de ingresos. Además, soy consciente de que tengo 10 días hábiles para presentar mi verificación de ingresos.
- Si solicito una visita confidencial, la agencia me recomienda realizar pagos mensuales en mi factura.
- Se espera el pago de los servicios en el momento del servicio. Como cortesía, es posible que se facture a mi seguro.
- Mi firma servirá como "firma registrada" legal a los efectos de presentar mis reclamos de seguro y pago de beneficios médicos por los servicios prestados.
- Como parte de la visita, algunos servicios de laboratorio no se pueden completar en la clínica. Es posible que reciba una factura de la empresa de laboratorio externa y seré responsable del costo de cualquier servicio de laboratorio.
- **Si soy menor de 18 años y he proporcionado la información de ingresos/seguro de mis padres/tutor para fines de facturación, acepto discutir todas las tarifas/seguro/facturación y la información de pago con ese padre o tutor.**
- Doy voluntariamente mi consentimiento para que la División de Salud Pública del Condado de Rockingham use y/o divulgue información de salud protegida para fines de tratamiento, pago y operaciones de atención médica, que pueden incluir información de naturaleza privada y sensible (como enfermedades de transmisión sexual).
- Doy mi consentimiento voluntariamente para exámenes, tratamientos y procedimientos médicos que se consideren necesarios en opinión de mi médico y proveedores de atención médica, incluidos VIH y pruebas de laboratorio.
- Mi información médica es estrictamente confidencial y está protegida por el Estatuto General 130A-143 de Carolina del Norte.
- Mi firma reconoce que se me ha brindado la oportunidad de hacer preguntas sobre este formulario de consentimiento y la oportunidad de rechazar servicios para mí o como representante personal verificado de la persona que está siendo atendida.
- Puedo recibir recordatorios de citas por correo electrónico, teléfono o mensaje de texto.
- Este consentimiento es válido por un año a menos que sea revocado por escrito.

¿Podemos facturar a su seguro si su diagnóstico y/o tratamiento incluyen servicios de ETS?

☐ Si, doy permiso ☐ No, doy permiso

Su información médica de RCDHHS se comparte con la Autoridad de Intercambio de Información de Salud de Carolina del Norte (HIEA). Si desea excluirse de HIEA, solicite el formulario de exclusión voluntaria con un miembro del personal.

_____ _____/_____/_____
Firma del Cliente/Representante Pesonal Verificado Fecha

_____ _____/_____/_____
Firma del Entrevistador Fecha

(Translated by CG)

Patient label

Rockingham County Health and Human Services
Dental Clinic
Terms and Conditions for Our Clients/
Acknowledgement of Receipt of Notice of Privacy Practices

- I was offered a copy of the Rockingham County Health and Human Services Notice of Privacy Practices.
- Upon penalties prescribed by law, I hereby affirm that to the best of my knowledge and belief, this income statement is true and correct.
- I understand that my signature will serve as legal "signature on file" for purposes of filing my insurance claims and payment of medical benefits to the Rockingham County Division of Public Health for services rendered.
- I give permission for Rockingham County Health and Human Services (RCHHS) to release any medical information which is requested by Medicaid, other insurance companies, or other agencies assisting in my care.
- I give permission for my photo to be taken by camera or ID to be copied and used to identify me and assist in my care. This is for RCHHS's use only and will not be released to any other source without my written permission.
- I understand that I may receive email, phone or text appointment reminders.
- I give permission for RCHHS to check income and insurance coverage through employers and/or other sources as necessary to determine my eligibility for services.
- I understand that fees for services may be reduced upon verification of income eligibility. Also, I am aware that I am allowed ten (10) business days to submit my income verification.
- I understand that I may receive services or be referred for services provided by other physicians, laboratories, hospitals, or other agencies. I understand fees that other agencies charge are my personal responsibility.
- I understand that payment for services is expected at the time of service, as a courtesy if I have Medicaid or private dental insurance RCHHS will bill them for my treatment.
- I understand that if I have Medicaid and other dental insurance, Medicaid will pay after my other dental insurance pays.
- I understand that Medicaid and private dental insurances do not pay for every procedure I may need. I am personally responsible for any part of my bill not covered by Medicaid or other dental insurances. I understand that I must pay my balance if my insurance does not pay in 60 days. I am aware that, if I have questions or concerns with what my insurance plan covers or pays, I can talk with my insurance company.
- I understand in the event RCHHS fails to bill for a procedure that was performed they will bill me or my third party payor.
- I understand that if outstanding balances remain unpaid, RCHHS has the right, unless restricted by State or Federal regulations, to refuse or deny further services to me.
- I request that Medicaid or other insurance payments for services received through RCHHS are to be paid directly to RCHHS. I agree to pay RCHHS any money that I receive from any source that is sent directly to me as payment for services that I have received from RCHHS. I will make this payment within 45 days of the day that I receive this money.
- I will notify RCHHS of any changes in my income, insurance, address, and phone number for program services.
- I understand that this consent is valid for one year unless I revoke it in writing.
- My signature acknowledges that no guarantees or warranties have been made to me concerning the results of the examinations, treatments, or procedures and I have been given the opportunity to ask questions about this consent form and the opportunity to refuse services for me or as the verified personal representative of the individual named above.

Your Medical information from RCHHS is shared with NC Health Information Exchange Authority (HIEA).If you wish to opt out of HIEA, please request the Opt Out Form from a staff member.

_____ _____/____/_____

Signature of patient, parent, or legal guardian *Date*

_____ _____/____/_____

Signature of Interviewer *Date*

Patient label

Departamento de Salud y Servicios Humanos del Condado de Rockingham Clínica Dental
Términos Y Condiciones Para Nuestros Clientes/
Reconocimiento de Recibo de Aviso de Prácticas de Privacidad

- Me ofrecieron una copia del Aviso de Prácticas de Privacidad del División de Salud Pública del Condado de Rockingham. (Today, I received a copy of the Rockingham County Division of Public Health Notice of Privacy Practices.)
- Bajo pena legal, por la presente hago constar que a mi mayor conocimiento y creencia, esté estado de ingreso es verdadero y correcto.
- Entiendo que mi firma sirve como "firma en expediente" ("signature on file") con el propósito de solicitar mi seguro dental y los pagos por el servicio dental recibido por parte del División de Salud Pública del Condado de Rockingham.
- Doy permiso al Departamento de Salud y Servicios Humanos del condado de Rockingham (RCHHS) por siglas en inglés de dar información médica que sea solicitadas por Medicaid, compañías de seguro, u otras agencias que hayan cuidado de mi salud.
- Doy permiso para que mi foto sea tomada por cámara o que tome una copia de mi identificación con fotografía para el uso de identificar y asistir en mi cuidado. Esto es solamente para el uso de RCHHS y no será divulgado a ningún otro medio sin mi permiso por escrito.
- Entiendo que puedo recibir recordatorios de citas por correo electrónico, teléfono, o texto.
- Doy permiso a RCHHS para verificar los ingresos y la cobertura del seguro a través de los empleados y/u otras fuentes según sea necesario para determinar mi elegibilidad para los servicios.
- Entiendo que el costo por servicios pueden reducirse al verificar la elegibilidad de ingresos. Además, soy consciente de que tengo un plazo de diez (10) días hábiles para enviar mi verificación de ingresos.
- Entiendo que puedo recibir servicios o ser referido para servicios a otros proveedores médicos, laboratorios, hospitales u otras agencias. Entiendo que las tarifas que otras agencias me cobren son mi responsabilidad personal.
- Entiendo que el pago por los servicios debe hacerse al mismo tiempo, como una cortesía si tengo Medicaid, Health Choice o seguro dental privado RCHHS les cobran a ellos por mi tratamiento.
- Entiendo que si tengo Medicaid y otro seguro dental, Medicaid pagará después de que mi seguro dental pague.
- Entiendo que Medicaid y los seguros dentales privados no pagan por todos los procedimientos que pueda necesitar. Soy personalmente responsable de cualquier parte de mi fractura que no sea cubierta por Medicaid u otros seguros dentales. Entiendo que debo pagar mi saldo si mi seguro no paga en 60 días. Soy consciente de que si tengo preguntas o preocupaciones con lo que mi plan de seguro cubre o paga, puedo hablar con mi compañía de seguro.
- Entiendo que en el caso de que RCHHS no fracture un procedimiento que se realizó, me facturaran a mí o a mi tercero pagador.
- Entiendo que si los saldos pendientes continúan sin pagarse, RCHHS tiene el derecho a menos que haya restricción por parte de reglamentos estatales o federales, a rehusar o negar servicios adicionales.
- Yo solicito que Medicaid, u otro pago de seguro por servicios que recibo a través de RCHHS sean pagados directamente a RCHHS. Yo estoy de acuerdo en pagar a RCHHS cualquier dinero que yo reciba de otro recurso que haya sido enviado directamente a mí como pago por servicios recibidos en RCHHS. Haré este pago dentro de cuarenta cinco (45) días de haber recibido el dinero.
- Yo notificará a RCHHS de cualquier cambio en mi ingreso, seguro, dirección, y número de teléfono para los servicios de este programa.
- Entiendo que este consentimiento es válido por un año a menos que lo anule por escrito.
- Con mi firma reconozco que no se me ha garantizado o asegurado con respecto a los resultados de los exámenes, tratamientos o procedimientos y me han dado la oportunidad de hacer preguntas sobre este formulario de consentimiento y la oportunidad de rehusar los servicios para mí o el verificado representante del individuo nombrado arriba.

Your Medical information from RCHHS is shared with NC Health Information Exchange Authority (HIEA).If you wish to opt out of HIEA, please request the Opt Out Form from a staff member.

_____ _____/_____/_____

Firma de Paciente o Padre/Tutor Legal ***Fecha***

_____ _____/_____/_____

Firma del Entrevistador/Signature of Interviewer ***Fecha***

Rockingham County Department of Health and Human Services

Division of Public Health Services Dental Clinic
371 NC HWY 65 ~ P.O. Box 204
Wentworth, NC 27375 – 0204
Phone (336) 342-8273
Fax (336) 342-8356

Sliding Fee Discount Application

I confirm that the information below is correct and accurate to the best of my knowledge. I have reported all income sources to Rockingham County Dental Clinic and have correctly listed all household members. If any information changes (number living in household, annual income, etc.), I understand I am to report this to the Dental Clinic front office staff at the next visit. This application must be updated annually. Should it come to our knowledge that the information provided is fraudulent or misleading, the patient will not be allowed to use the Sliding Fee Scale and will be placed 100% responsible for payment as long as he/she remains a patient.

Verification of Family Income

Please fill out the information below regarding the income of the entire household. The household includes all members living in the house. The family income is considered all **gross income** brought in by all members of the household.

Patient Full Name:_____ Date of Birth:_____/_____/_____

Responsible Party (if patient is a minor):_____

Income Worksheet:

Name of Each Family Member	Income of Each Family Member	Proof of Income/Type of Documentation	Weekly/Bi-weekly/ Monthly/Yearly

Number in Household:_____ Number that works in Household:_____

Income of Household (combine income of all members of the family)_____

Office Use Only

Sliding Scale Placement Percentage:_____

I understand that I am financially responsible for all charges.

_____ _____/_____/_____

Signature of Patient, Parent, or Legal Guardian *Date*

_____ _____/_____/_____

Signature of Interviewer *Date*

Departamento de Salud yServicos Humanos del Condado de Rockingham

Division of Public Health Services Dental Clinic
371 NC HWY 65 ~ P.O. Box 204
Wentworth, NC 27375 – 0204
Phone (336) 342-8273
Fax (336) 342-8356

Solicitud de Descuento de Tarifa Móvil

Confirmó que la información a continuación es correcta y precisa a mi leal saber y entender. He informado todas las fuentes de ingresos a la Clínica Dental del Condado de Rockingham y he enumerado correctamente todos los miembros de la familia. Si cambia cualquier información (número de personas que viven en el hogar, ingresos anuales, etc.), entiendo que debo informar esto a la oficina en la próxima visita. Esta aplicación debe actualizarse anualmente. En caso de que lleguemos a nuestro conocimiento que la información provista es fraudulenta o engañosa, no se le permitirá al paciente utilizar la escala de tarifas variables y se le asignará el 100% siempre que continúe siendo un paciente.

Verificación del Ingreso Familiar

Completa la información a continuación con respeto a los ingresos de toda la familia. El hogar incluye a todos los miembros que viven en la casa. El ingreso familiar se considera como el **ingreso en bruto** aportado por todos los miembros del hogar.

Nombre completa del paciente:_____ Fecha de nacimiento::____/____/____

Parte responsable (si el paciente es menor):_____

Tabla de Ingresos:

Nombre de Cada Miembro de la Familia	Ingresos de Cada Miembro de la Familia	Tipo de Documentación	Semanal/Quincenal/ Mensual/Año

Número en el Hogar:_____ Número que trabajan en Hogar:_____

Ingresos del Hogar (ingreso combinado de todos los miembros de la familia)_____

Office Use Only

Sliding Scale Placement Percentage:_____

Entiendo que soy financieramente responsable de todos los cargos.

_____ _____/_____/_____

Firma de Paciente o Padre/Tutor Legal *Fecha*

_____ _____/_____/_____

Firma del Entrevistador/Signature of Interviewer *Fecha*

Rockingham County Department of Health and Human Services

Division of Public Health Services

371 NC HWY 65 ~ P.O. Box 204 **Wentworth, NC 27375 – 0204**
Phone (336) 342-8140 **Fax (336) 342-8356**

PAYMENT AGREEMENT FORM

In accordance with the policy of the Health Department, payment is due when service is rendered. However, we realize that there are times when an individual does not have the total amount of money owed to the clinic, therefore, this written agreement is established as a method of adopting a payment plan for those patients who have an outstanding balance.

Name _____Date of Birth _____

SSN/ITIN _____ Phone _____

Address _____

I, _____, agree to establish a payment plan for my account and to the stipulations herein stated:

My account balance is $_____. I will pay the amount of $_____ on my bill.

☐ Monthly ☐ Weekly ☐ Bi-weekly

(*Please initial each line below.)*

_____ I understand that Rockingham County Division of Public Health Services cannot operate efficiently without my adhering to the agreement as stated above. I further state that my options were explained to me and I fully understand.

_____ I understand that I am responsible for any balance left owing if my insurance company should not pay the bill in full and that it will be based on my sliding fee scale status.

_____ I understand if I fail to make payments as agreed above, Rockingham County Division of Public Health Services will recoup the balance owed through the NC Debt SetOff Program.

This is a binding agreement by signature of both parties. The agreement will be filed in the patient's record as a permanent document.

Failure to comply with this agreement will greatly affect the overall services of the Health Department operation.

Signature of Patient _____

Signature of Witness _____

Date _____

Rockingham County Department of Health and Human Services

Division of Public Health Services

371 NC HWY 65 ~ P.O. Box 204 **Wentworth, NC 27375 – 0204**
Phone (336) 342-8140 **Fax (336) 342-8356**

Formulario de acuerdo de pago

De acuerdo con la política del Departamento de Salud, el pago se debe cuando se presta el servicio. Sin embargo, nos damos cuenta de que hay momentos en que un individuo no tiene la cantidad total de dinero que se debe a la clínica, por lo tanto, este acuerdo escrito se establece como un método de adoptar un plan de pago para los pacientes que tienen un saldo pendiente.

Nombre_____ Fecha de nacimiento_____

SSN/ITIN_____Tel. _____

Dirección_____

Yo, _____, estoy de acuerdo en establecer un plan de pago para mi cuenta y las estipulaciones que aquí se establecen:

El saldo de mi cuenta es $_____ . Pagaré la cantidad de $_____en mi factura.

☐Mensual ☐Semanal ☐Quincenal

(por favor sus iniciales en cada línea)

_____ Entiendo que la División de Servicios de Salud Pública del Condado de Rockingham no puede operar eficientemente sin mi adhesión al acuerdo como se mencionó anteriormente. Declaro además que mis opciones se me explicaron y entiendo completamente.

_____ Entiendo que soy responsable de cualquier saldo restante debido si mi compañía de seguros no debe pagar la cuenta en su totalidad y que se basará en mi estado de escala de tarifas de desplazamiento.

_____ Entiendo que si no cumplo con los pagos acordados anteriormente, la División de Servicios de Salud Pública del Condado de Rockingham recuperará el saldo adeudado a través del Programa de Liquidación de Deudas de NC.

Este es un acuerdo vinculante por la firma de ambas partes. El acuerdo será archivado en el expediente del paciente como un documento permanente.

El incumplimiento de este acuerdo afectará en gran medida los servicios generales de la operación del Departamento de Salud.

Firma del paciente _____

Firma del testigo _____

Fecha _____

Rockingham County Department of Health and Human Services

Division of Public Health Services
371 NC HWY 65 ~ P.O. Box 204, Wentworth, NC 27375 – 0204

DATE

Client Name
Address
Address

RE:

Dear Client Name,

On (Date called), I left a message for you regarding a returned check.

We have received a check back from the bank stating that there were non-sufficient funds. The check has been voided in our system and the payment is due on the account. A copy of the check is enclosed for your records. The amount due is (amount owed). Please make arrangements to pay this amount either by cash or money order within 30 days from the date of this letter.

You can choose to either mail your payment or make your payment in person. Please do one of the following:

1) To mail your payment: please mail your money order (do not send cash) to Rockingham County Health Department Attn: Billing Office, P. O. Box 204, Wentworth, NC 27375.
2) To make your payment in person: please come to the Health Department and ask for Billing Office.

If you have any questions, please feel free to contact our billing department at 342-8143.

Thank you,

_____
Rockingham County Division of Public Health
Billing Office

/attachment

Letter 1

Rockingham County Department of Health and Human Services

Division of Public Health Services
371 NC HWY 65 ~ P.O. Box 204, Wentworth, NC 27375 – 0204

CERTIFIED MAIL

DATE

Client Name
Client Address
Client Address

Dear Client Name:

Please be advised that your check (#_____) in the amount of $_____ tendered by you to the Rockingham County Division of Public Health on _____ was returned for the following reason(s):

- Insufficient funds
- Nonexistent account
- Closed account

Please remit payment in the following amount:

Face value of the check	$_____
Bank service fee	$_____
Returned check fee	$_____ (Maximum $25.00)
TOTAL AMOUNT DUE	$_____

If the total amount due is not paid within fifteen (15) days from the date of this letter, we will turn this matter over to the Worthless Check Program Coordinator with the Office of the District Attorney of Rockingham County. At that point, all further efforts to resolve the matter will be handled by that office.

Sincerely,

_____
Rockingham County Division of Public Health
Billing Department

Rockingham County Department of Health and Human Services

Division of Public Health Services

371 NC HWY 65 ~ P.O. Box 204 **Wentworth, NC 27375 – 0204**
Phone (336) 342-8140 **Fax (336) 342-8356**

CONFIDENTIALITY
PAYMENT AGREEMENT FORM

In accordance with the policy of the Health Department, payment is due when service is rendered. However, we realize that there are times when an individual does not have the total amount of money owed to the clinic, therefore, this written agreement is established as a method of adopting a payment plan for those patients who have an outstanding balance.

Name _____Date of Birth _____

SSN/ITIN _____ Phone _____

Address _____

I, _____, agree to establish a payment plan for my account and to the stipulations herein stated:

My account balance is $_____.

I will pay the amount of $_____ on my bill.

☐ Monthly ☐ Weekly ☐ Bi-weekly

(*Please initial each line below.)*

_____ I understand that Rockingham County Division of Public Health Services cannot operate efficiently without my adhering to the agreement as stated above. I further state that my options were explained to me and I fully understand.

_____ I understand that I am responsible for any balance left owing if my insurance company should not pay the bill in full and that it will be based on my sliding fee scale status.

This is a binding agreement by signature of both parties. The agreement will be filed in the patient's record as a permanent document.

Failure to comply with this agreement will greatly affect the overall services of the Health Department operation.

Signature of Patient _____

Signature of Witness _____

Date _____

Rockingham County Department of Health and Human Services

Division of Public Health Services

371 NC HWY 65 ~ P.O. Box 204 **Wentworth, NC 27375 – 0204**
Phone (336) 342-8140 **Fax (336) 342-8356**

Formulario de Acuerdo de Pago de Confidencialidad

De acuerdo con la política del Departamento de Salud, el pago se debe cuando se presta el servicio. Sin embargo, nos damos cuenta de que hay momentos en que un individuo no tiene la cantidad total de dinero que se debe a la clínica, por lo tanto, este acuerdo escrito se establece como un método de adoptar un plan de pago para los pacientes que tienen un saldo pendiente.

Nombre_____Fecha de nacimiento_____

SSN/ITIN_____Tel. _____

Dirección_____

Yo, _____, estoy de acuerdo en establecer un plan de pago para mi cuenta y las estipulaciones que aquí se establecen:

El saldo de mi cuenta es $_____.

Pagaré la cantidad de $_____ en mi factura.

☐ Mensual ☐ Semanal ☐ Quincenal

(*por favor sus iniciales en cada línea)*

_____ Entiendo que la División de Servicios de Salud Pública del Condado de Rockingham no puede operar eficientemente sin mi adhesión al acuerdo como se mencionó anteriormente. Declaro además que mis opciones se me explicaron y entiendo completamente.

_____ Entiendo que soy responsable de cualquier saldo restante debido si mi compañía de seguros no debe pagar la cuenta en su totalidad y que se basará en mi estado de escala de tarifas de desplazamiento.

Este es un acuerdo vinculante por la firma de ambas partes. El acuerdo será archivado en el expediente del paciente como un documento permanente.

El incumplimiento de este acuerdo afectará en gran medida los servicios generales de la operación del Departamento de Salud.

Firma del paciente _____

Firma del testigo _____

Fecha _____

NORTH CAROLINA
DEPARTMENT OF STATE TREASURER

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

UNCLAIMED PROPERTY

BRENDA D. WILLIAMS
DEPUTY TREASURER

Guide to Unclaimed Property Due Diligence

Refer to House Bill 294— Notice by holders to apparent owner.

When an owner's money is escheated, they often express dissatisfaction when they discover that the holder has not made a diligent effort to contact them about their property. Currently, for items having a property value of $50 and greater, the law requires a holder to send a written notice to an owner, at the owner's last known address according to the records of the holder. The notice should inform the owner that the holder is in possession of the owner's property and if the owner does not acknowledge their property, their property will be turned over to the North Carolina Department of State Treasurer Unclaimed Property Division.

As the law requires simultaneous reporting and remittance, it is important to practice "due diligence" in trying to locate owners prior to reporting their funds to the Unclaimed Property Division. If the address on record is known to be invalid, the holder shall exercise reasonable care to ascertain the correct address of the apparent owner. Notices must be mailed 60-120 days in advance of the November 1 report due date (May 1 if the holder is a life insurance company). This will allow the owner time to respond. A sample due diligence letter is on the following page.

Beginning with due diligence notices sent October 1, 2017 and forward;

- For property that is a security, or other equity interest in a business association, the threshold for the notice requirement is a property value of $25.00 or more. For all other property types, the threshold for the notice requirement will remain at $50.00 or more property value.
- Holders must exercise reasonable care to ascertain that they are sending the written notice to the apparent owner's correct address.
- The required notice shall include contact information of the holder and a statement, that, once property is placed in the custody of the Treasurer, all interest, dividends, income, and gains earned on the property will remain with the Treasurer, even if the owner subsequently reclaims the property from the Treasurer.
- Holders violating the notice requirement are subject to the penalties applicable to other violations of the North Carolina Unclaimed Property Act.

3200 Atlantic Avenue • Raleigh, North Carolina 27604
Telephone: (919) 814-4200 • Fax: (919) 855-5811 • www.NCCash.com

Fred Wright III, Health Director

Rockingham County Department of Health and Human Services

Division of Public Health Services
371 NC HWY 65 ~ P.O. Box 204, Wentworth, NC 27375 – 0204

Patient Name: _____ Account Number: _____

NOTE: If Medicare doesn't pay for services below, you may have to pay. Medicare/Medicare Advantage Plan does not pay for everything, even some care that you or your health care provider have good reason to think you need.

Service	Reason Medicare May Not Pay:	Estimated Cost
Flu – High Dose Vaccine & Admin Flu - Standard COVID Vaccine & Admin	Provider not in-network with your insurance	$112 – Flu High Dose $62 – Flu Standard $200 - COVID

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

I want the services listed above. I want Medicare/Medicare Advantage to be billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment.

Additional Information:

This notice gives our opinion, not an official Medicare/Medicare Advantage decision.

Signing below means that you have received and understand this notice. You may ask to receive a copy.

Signature:	Date:

Fred Wright III, Health Director

Rockingham County Department of Health and Human Services

Division of Public Health Services
371 NC HWY 65 ~ P.O. Box 204, Wentworth, NC 27375 – 0204

Nombre del paciente: _____ Número de cuenta: _____

NOTA: Si Medicare/Medicare Advantage no paga por servicios a continuación, es posible que tenga que pagar. El plan Medicare/Medicare Advantage no paga todo, ni siquiera algunos cuidados que usted o su proveedor de atención médica tienen buenas razones para pensar que necesita.

Servicios	Razón por la que Medicare no puede pagar:	Costo estimado
Gripe: vacuna de dosis alta y administración **Gripe: Estándar** **Vacuna COVID y administración**	**Proveedor que no está dentro de la red con su seguro**	**$112 – Gripe** **$62 – Gripe Estándar** **$200 - COVID**

LO QUE NECESITA HACER AHORA:

- Lea este aviso para que pueda tomar una decisión informada sobre su cuidado.
- Háganos cualquier pregunta que pueda tener después de terminar de leer.

Quiero los servicios enumerados anteriormente. Quiero que se facture a Medicare/Medicare Advantage por una decisión oficial sobre el pago, que se me envíe en un Aviso resumido de Medicare (MSN). Entiendo que si Medicare no paga, yo soy responsable del pago.

Información adicional:

Este aviso da nuestra opinión, no es una decisión oficial de Medicare/Medicare Advantage.

Firmar a continuación significa que ha recibido y comprende este aviso. Puede solicitar recibir una copia.

Firma:	**Fecha:**

Fred Wright III, Health Director

Rockingham County Department of Health and Human Services

Division of Public Health Services
371 NC HWY 65 ~ P.O. Box 204, Wentworth, NC 27375 – 0204

3rd Party Insurance

Patient Name: _____ Account Number: _____

NOTE: If Insurance doesn't pay for services below, you may have to pay. Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need.

Service	Reason Insurance May Not Pay:	Estimated Cost
COVID Vaccine & Admin	Non-par provider; Deductible not met; Immunizations not covered under plan	$200 - COVID

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

Additional Information:

1. **Does your insurance pay for immunizations? Yes _____ No _____**

2. **Will immunizations apply towards your yearly deductible? Yes _____ No _____**
   If yes, have you met your yearly deductible for this year? Yes _____ No _____

I want the services listed above. I want my insurance to be billed for an official decision on payment, which is sent to me on an insurance explanation of benefits. I understand that if my insurance doesn't pay, I am responsible for payment.

This notice gives our opinion, not an official insurance decision.

Signing below means that you have received and understand this notice. You may ask to receive a copy.

Signature:	Date:

Fred Wright III, Health Director

Rockingham County Department of Health and Human Services

Division of Public Health Services
371 NC HWY 65 ~ P.O. Box 204, Wentworth, NC 27375 – 0204

Seguro de terceros

Nombre del paciente: _____ **Número de cuenta:** _____

NOTA: Si el seguro no paga por servicios a continuación, es posible que tenga que pagar. El seguro no paga todo, ni siquiera algunos cuidados que usted o su proveedor de atención médica tienen buenas razones para pensar que necesitan.

Servicios	Razón por la que Medicare no puede pagar:	Costo estimado
Vacuna COVID y administración	**Proveedor no par; Deducible no alcanzado; Vacunas no cubiertas por el plan**	**$200 - COVID**

LO QUE NECESITA HACER AHORA:

- Lea este aviso para que pueda tomar una decisión informada sobre su cuidado.
- Háganos cualquier pregunta que pueda tener después de terminar de leer.

Información adicional:

1. **¿Su seguro paga las vacunas? Sí _____ No _____**
2. **¿Se aplicarán las vacunas a su deducible anual? Sí _____ No _____**
   En caso afirmativo, ¿ha cumplido con su deducible anual para este año? Sí ____ No____

Quiero los servicios enumerados anteriormente. Quiero que se facture a mi seguro una decisión oficial sobre el pago, que se me envía junto con una explicación de los beneficios del seguro. Entiendo que si mi seguro no paga, soy responsable del pago.

Este aviso da nuestra opinión, no una decisión oficial del seguro.

Firmar a continuación significa que ha recibido y comprende este aviso. Puede solicitar recibir una copia.

Firma:	**Fecha:**

Rockingham County Department of Health and Human Services
Division of Public Health Services
371 NC HWY 65 Reidsville, NC 27320~ P.O. Box 204, Wentworth, NC 27375 – 0204
336-394-0081

FINANCIAL HARDSHIP APPLICATION

Please complete the following form, and submit all necessary supporting documentation to our practice. For your security, we recommend that this sensitive information be delivered in person to our practice.

Continued Eligibility: If a waiver is granted, it will automatically expire after a period of six months. Periodically, you may be required to re-certify your financial status. If any of the information that you have provided proves to be untrue, we will promptly reevaluate your financial status and take action necessary to collect on your account. If granted, a waiver may be immediately revoked by the practice, without advance notice, for any reason.

All information relating to this application are kept completely confidential and will only be used to determine eligibility.

Account Number _____ Date _____

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: ____ / ____ / ____ SS#: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Other Contact: _____

Name of person completing application (*if other than above*) _____

Relationship to patient _____

Insurance Information ☐ Medicare ☐ Medicaid ☐ Other (please specify) _____

Primary Insurance _____ ID# _____

Secondary Insurance _____ ID# _____

Please answer all the following questions:

Employment Status: ☐ Employed ☐ Unemployed. If so, how long? _____ ☐ Retired ☐ Disabled

Number of family members living in the household: ____ Housing Status: ☐ Rent ☐ Own Monthly pmt $_____

	Patient	**Spouse/Partner**	**Dependents/Others**
Monthly Salary (Gross)	$_____	$_____	$_____
Public Assistance Benefits	$_____	$_____	$_____
Unemployment Benefits	$_____	$_____	$_____
Social Security Benefits	$_____	$_____	$_____
Workman's Compensation	$_____	$_____	$_____
Child Support	$_____	$_____	$_____
Other (Alimony, Etc.)	$_____	$_____	$_____
Subtotal:	$_____	$_____	$_____

TOTAL FAMILY INCOME $_____

Explain why you are unable to pay your medical bill(s):

_____

_____

Rockingham County Department of Health and Human Services
Division of Public Health Services
371 NC HWY 65 Reidsville, NC 27320~ P.O. Box 204, Wentworth, NC 27375 – 0204
336-394-0081

Please submit TWO of the following documents:

- ☐ Copies of pay-stubs (3 months)
- ☐ Copy of Social Security Income, Social Security Disability, General Assistance or Aid to Dependent Children benefit letter
- ☐ Copy of bank statements (3 months)
- ☐ Employment verification letter including YTD earnings and pay rate.
- ☐ Copy of Federal & State Tax Returns or W-2 statements for past 2 years
- ☐ Copy of your Medicaid denial letter (*if requested*)

I HEREBY CERTIFY THAT NO OTHER SOURCE, INCLUDING MEDICAID, WELFARE PROGRAM, PARENT OR OTHER PERSON OR PROGRAM IS LEGALLY RESPONSIBILE FOR MY BILLS. I CERITIFY THAT THE INFORMATION ON THIS FORM AND SUPPORTING DOCUMENTATION IS TRUE AND CORRECT. I AUTHORIZE ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF PUBLIC HEALTH SERVICES TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____ _____
Applicant Signature Date:

Return form and documents to:
Rockingham County Health and Human Services
Attn: Billing Office
PO Box 204
Wentworth, NC 27375-0204

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: **ACCOUNTS PAYABLE, PURCHASING, AND CONTRACTING PROCEDURES**

DATE DEVELOPED: **11/96**
REVIEWED: **6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/15; 6/20; 6/23**

I. POLICY:

The Division of Public Health Services shall follow the accounts payable, purchasing, and contracting procedures set forth by the County Finance Office, and the Personnel and Purchasing Office. *(Refer to the County's Policies and Procedures Manual in Administration.)*

II. PURPOSE:

Sufficient unencumbered funds must remain to meet department obligation. The purchase order system is the mechanism to provide a systematic preaudit of purchases before an order is placed.

III. GUIDELINES:

A. PURCHASING

PURCHASE ORDERS – A form generated by the Purchasing Department for County expenditures. It serves as a legal contract document to a vendor to order goods and services.

1. Ordering goods whether by telephone, letter, fax, email, or purchase order creates an obligation and must be preaudited.

2. Purchase orders are required for all orders costing $499.99 or more as per the County's finance department.

3. Purchase orders should always be obtained before the order is placed.

4. Requisitions are entered in the County's Automated Financial System to process and record all County procurement financial activity.

5. Quotations – General policy of the County has been to obtain at least three (3) informal quotes for any purchase of apparatus, supplies, materials or equipment that requires an expenditure of more than $500.00.

6. All three quotes must be entered on the electronic requisition in the County's financial system. This typically applies to capital requests attached to project codes.

B. BLANKET PURCHASE ORDERS – Informal Bids

May be issued for repetitive purchases from a single vendor. The health department must keep track of balance left on P.O. and cannot make purchases when this amount is depleted.

C. DIRECT PURCHASES

The following goods and services may be purchased without the use of a purchase order:

1. Orders for less than $499.99

2. Travel expenses, conference and meeting registrations

3. Food Purchases

4. Dues and Subscriptions

5. Social Services (General Assistance and Public Assistance Programs)

6. Utility Bills (Telephone, power, water, etc.)

7. License Renewals

8. Professional Contracted Services (such as labs, hospitals, etc.)

9. Procurement Card Purchases

D. REQUESTS FOR SUPPLIES

Requests for goods and services must be documented on the department's requisition form. The requisition form is completed electronically. The employee requesting supplies fills out the form and must include the vendor

name, if known, the date of the request, the program(s) the supplies will be used in and charged, quantity, catalog number, and a description of the supplies.

1. The requisition form must be signed electronically by the employee who is requesting the goods or supplies, and the section supervisor who is approving the request. In some cases, the health director's signature is also required.

2. Approved requisition forms should be submitted daily to Administration. Requisitions are processed daily.

3. Approved requests for ***R U S H*** items are processed immediately upon receipt from the employee.

4. Verification of appropriate funding listed on the Account Activity Summary Report should be confirmed by the section supervisor prior to approving requisitions for supplies.

E. PRINTING

All printing needs of the health department should be sent electronically to the Accounting Assistant on a requisition form.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: FIXED ASSETS ACCOUNTING DEPRECIATION POLICY

DATE DEVELOPED: 3/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services' depreciation method will be straight-line depreciation and the base dollar value for capitalization will be $2,500. Depreciation calculations are performed by the Rockingham County Finance Department at the end of each Fiscal year.

Note:
Policy developed in consultation with Mike Apple, C.P.A., Assistant County Manager/Director of Financial Services, on 2/16/04 to document agency's compliance with the Consolidated Agreement requirements regarding fixed assets depreciation.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ESTABLISHING FEE RATES FOR SERVICES

DATE DEVELOPED: 11/10
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/20

I. POLICY:

All clinical services available at the Division of Public Health Services have a fee. These charges will be passed on to the client when applicable, based on insurance availability as well as eligibility status.

II. PURPOSE:

To define the process for determining fees for services rendered by the Division of Public Health Services.

III. GUIDELINES:

The "Medicaid Cost Analysis" is a tool/ method utilized to determine how much it cost the Health Department to provide a service. This study is performed annually in all health departments and the actual results are shared with each county. This information gives a realistic figure to work with and compares cost to perform a service. Other contributing factors, used in determining cost include examining the time it actually takes to provide the service (staff cost), supply cost, health department market rates, Medicaid and Medicare rates, private practice rates, cost study rates, and related indirect costs.

The cost of providing flat rate fees is also determined through this procedure and may be established for specific services that are not funded by State/Federal funds. An example is the TB skin test (related to work or school).

Once the above information has been reviewed and discussed with the Health Department staff and upon the approval of the Health Director, fees will be taken to the Board of Health and Human Services and Board of County Commissioners, per G.S. 130 A-39(g), for their discussion and final approval. This information will be reflected in the appropriate minutes, for future review. The appropriate fees set will be maintained in the Health Department, noted as approved "Fees-Effective". Electronic Health Record (EHR) systems will be updated with the fee schedule prior to the beginning of each fiscal year and as necessary when fee schedule changes. Start and end dates will apply in these systems for all fee schedules.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: HEALTH SERVICES ANALYSIS

DATE DEVELOPED: 02/2018
REVIEWED: 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/22

I. PURPOSE:

To assure that Division of Public Health Services complies with legal requirements for reporting high level clinical service data to the NC Division of Public Health (DPH). The policy details the security measures involved in the reporting process for clinical data exchanged between the NC Division of Public Health-State Center for Health Statistics and Division of Public Health Services.

II. POLICY:

It is the policy of Rockingham County Department of Health and Human Services (RCDHHS), Division of Public Health Services to require the contracted electronic health record (EHR) vendor to capture required data in its electronic health record. Division of Public Health Services will require its EHR vendor to create a data extract in the format specified by DPH.

Only personnel authorized by DPH can access the CrushFTP secure server for the transfer of data with DPH. RCDHHS, Division of Public Health Services will assure that at least two authorized users maintain credentials always.

III. PROCEDURE:

A. Health Director designates at least two CrushFTP users
B. Each user will:

1. Complete S-FTP Access Request form obtained from DPH;
2. Comply with the NC DHHS Privacy and Security Policy: Acceptable Use for DHHS Information Systems;
3. Complete training provided by DPH;
4. Contact CrushFTP support (919-792-5877) or LHD-HSA Help Desk support (919-792-5793).

C. Passwords for the CRUSH SFTP server may never be shared. Users must transfer data to and from the server from the IP address given with approval. If IP address changes, contact CrushFTP support (919-792-5793).

D. Upload of files to DPH

1. Division of Public Health Services uploads its own files to the CrushFTP server, or
2. The EHR vendor for RCDHHS, Division of Public Health Services uploads files to the CrushFTP server
3. Upload occurs at least every 30 days and follows the suggested upload schedule published by DPH when possible.

E. Checking email for processed files

1. Credentialed users check email daily on workdays for notifications that files have been processed.
2. Credentialed users review the file summary.
3. If the processed file(s) are without error, then no further action is needed.

Note: Processed files are automatically moved to "processed" folder on CrushFTP.

F. Checking server for error reports

1. If the processed file(s) indicated errors, then user signs on to the CrushFTP server and reviews the error report.
2. The user may download a copy of the error report to a secure folder on a local server designated for LHD-HSA reporting. The error report will contain personally identifiable information (PII).

Note: Error files will be deleted from CrushFTP on a periodic basis by CrushFTP support.

G. Correcting error reports

1. Users review the error reports and make corrections.
2. Some errors are technical while others may be clinical in nature.
3. Contact internal users, vendor, or LHD-HSA Help Desk (919-792-5793) as needed to understand and correct errors.

H. Resubmitting files to DPH

Division of Public Health Services should re-open files with changes/fixes within 7 days.

Note: Re-submission of files to correct errors will not create a duplicate in the master data.

The legal rights and responsibilities of patients and health care providers shall apply to records created or maintained in electronic form to the same extent as those rights and responsibilities apply to medical records embodied in paper or other media. This applies to security, confidentiality, accuracy, integrity, access to, and disclosure of medical records.

All electronic health records are maintained in accordance with the RCDHHS Division of Public Health Services policy on Electronic Records and Imaging *(ADM-33 Electronic Health Records; ADM-35 Electronic Records and Imaging, Scanning and Destruction of Records)*.

IV: RESPONSIBILITIES:

This policy is applicable to all employees of RCDHHS Division of Public Health Services including students, volunteers, temporary, and contractual staff. Supervisors are responsible for monitoring compliance with the policy.

V: LEGAL AUTHORITY:

HIPAA Health Insurance and Portability Act of 1996
NCGS § 130A-34.2. Billing of Medicaid.
NCGS § 90-412§. Electronic medical records**.**
NCGS § 130A-45.8. Confidentiality of patient information.
NCGS § 130A-15. Access to information.
NCGS § 130A-16. Collection and reporting of race and ethnicity data.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

GOVERNING BOARD/WORKFORCE POLICIES

**ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY**

TITLE: GOVERNING BOARD POLICY – OVERALL OPERATIONS

DATE DEVELOPED: 10/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16

I. POLICY:

The mission of the Governing Board is to build foundations for good health, safety, and well-being in the community by the adoption and enforcement of policies and regulations necessary to protect and promote the health, safety, and well-being of the citizens of Rockingham County through the provision of essential health and human services in the most efficient manner.

II. PURPOSE:

To state general policies that will guide the Governing Board in its delegation of duties. Authority provided under this policy is found in North Carolina G.S. 130A-34, 130A-40, 130A-41, 130A-24, and 153A-77.

III. GUIDELINES:

Health Director

A. The Human Services Director will employ a Health Director and delegate to him/her the authority and responsibility for the overall management of the affairs of the Division of Public Health in accordance with written policies. In the absence of written policies, the Health Director is to be guided by an application of Board intent as established in other policies and counseled where appropriate by the officers of the Board.

B. The Governing Board strives to ensure that a job description for the position of the Health Director includes appropriate qualifications of education, experience, personal factors, and skills. The Health Director shall guide his/her activities by the content and spirit of the job description.

C. The Governing Board strives to ensure that the Human Services Director/Health Director administers the Division of Public Health within conformance or a reasonable interpretation of North Carolina General Statutes.

D. The duties and the responsibilities of the Health Director are to:

1. Implement programs, policies, and fiscal plans.

2. Perform management functions, which will assure that program services will be available, accessible, acceptable, coordinated to promote continuity of care and meet appropriate standards.

3. Delegate authority and accountability for program functions to Health Department staff who are assigned managerial responsibilities.

4. Coordinate information with other governmental and private groups concerned with the planning and delivery of health and social services for which clients of the area are eligible.

5. Ensure performances of administrative functions, which will provide accountability for funds, received and expended and assure that all regulations and requirements are satisfied.

6. Manage the Division of Public Health staff addressing such functions as recruitment/hiring of licensed/credentialed and/or qualified staff, staff development, job descriptions, evaluation, termination, recommendations**,** grievance procedures, pension and related employee benefits.

7. Use statistical and other relevant information for determining needs, planning services, monitoring staff and program activity, and evaluating the attainment of objectives.

8. Present to the Board of Health and Human Services issues that may require board policy statements.

9. Approve the purchases of capital equipment approved by the Board in the budget ordinance or revision.

10. Develop the organizational structure for the Division of Public Health, prepare current organizational charts, and establish lines of communication.

E. G.S. 153A-77(e) - Powers and duties of the local human services director:

1. Appoint staff of the consolidated human services agency with the county manager’s approval.

2. Administer State human services programs.

3. Administer human services programs of the local board of county commissioners.

4. Act as secretary and staff to the consolidated human services board under the direction of the county manager.

5. Plan the budget of the consolidated human services agency.

6. Advise the board of county commissioners through the county manager.

7. Perform regulatory functions of investigation and enforcement of State and local health regulations, as required by State law.

8. Act as an agent of and liaison to the State, to the extent required by law.

9. Appoint, with the county manager's approval, an individual that meets the requirements of G.S. 130A-40(a).

Except as otherwise provided by law, the human services director or the director's designee shall have the same powers and duties as social services director, a local health director, or a director of an area mental health, developmental disabilities, and substance abuse services authority.

F. The human services director of a consolidated county human services agency shall be appointed and dismissed by the county manager with the advice and consent of the consolidated human services board. The human services director shall report directly to the county manager.

G. The Governing Board requests, when necessary, that legal counsel is consulted. The Legal Department is available to provide legal advice as requested regarding the legal adoption, dissemination, evaluation, improvement and enforcement of laws, rules and regulations surrounding the Rockingham County Department of Health and Human Services. Legal counsel reviews bylaws and rules for compliance with local, state and federal statutes and regulations.

H. The Board of Health and Human Services strives to assure the prevention, promotion and protection of the Rockingham County Department of Health and Human Services through its adoption, dissemination, evaluation, improvement and enforcement of laws and regulations that govern the services provided.

The Governing Board is kept updated on program events through the data and information obtained through internal program audits and through state and federal external audits.

I. Based on information presented to Governing Board, the Board will evaluate the necessity of additional rules, regulations or ordinances. The Governing Board, department management team and legal counsel will collaborate to establish the best alternatives and consider cost-effectiveness when making the necessary additions to the rules, regulations, or ordinances. The Rockingham County Department of Health and Human Services follows the "Plan-Do-Check-Act" (PDCA) Model for Improving Organizational Performance. The Governing Board shall follow the procedures for adopting rules in G.S. 130A-39.

J. The Governing Board maintains a relationship with the county commissioners by inducting a county commissioner to serve on the Governing Board.

K. The Governing Board provides an appeals process for Rockingham County citizens that wish to voice their concerns regarding the Rockingham County Department of Health and Human Services' interpretation or enforcement of local rules and regulations.

This process will consist of the following:

1. The appeals procedure shall be conducted as provided in N.C. General Statute 130A-24, as described below. The appeals procedure will reflect the most current version of the relevant statute.

2. The aggrieved person shall give written notice of appeal to the Rockingham County Health Director within 30 days of the challenged action. The notice shall contain the name and address of the aggrieved person, a description of the challenged action and a statement of the reasons why the challenged action is incorrect.

3. Within 5 working days upon filing of the notice, the Rockingham County Health Director shall transmit the notice of appeal to the Governing Board along with the papers and materials upon which the challenged action was taken.

4. Within 15 days of the receipt of the notice of appeal, the Governing Board shall hold a hearing.

5. The aggrieved person shall be given not less than 10 days notice of the date, time, and place of the hearing.

6. On appeal, the Governing Board shall have authority to affirm, modify or reverse the challenged action. The Board's decision shall be provided in writing based on the evidence presented at the hearing. The written decision shall contain a concise statement of the reasons for the decision.

7. A person who wishes to contest a decision of the Governing Board under subsection (b) of N.C.G.S. 130A-24 shall have a right of appeal to the Rockingham County District Court within 30 days after the date of the decision by the Board. The scope of review in district court shall be the same as in G.S. 150B-51.

L. The Governing Board strives to assure the Rockingham County Department of Health and Human Services is compliant as an affirmative action/equal opportunity employer. Rockingham County Department of Health and Human Services will afford equal opportunity to all qualified employees and applicants for employment regardless of race, national origin, color, religion, age, sex, creed, physical handicap, or political affiliation.

M. The Governing Board strives to assure that the Rockingham County Department of Health and Human Services accepts all clients who qualify for the services it provides without regard to race, national origin, color, religion, age, sex, creed, physical handicap or political affiliation or any other legally protected basis, and treats all clients accepted for services without discriminating on the basis of these categories in providing its services.

N. Formal training for Governing Board members shall be provided through DHHS sponsored offerings through the UNC School of Public Health – Institute of Public Health or equivalent approved training. Governing Board members are encouraged to attend beneficial continuing education updates which meet the needs of the Board and members after attending the general board member orientation.

The Governing Board members will receive a Rockingham County Department of Health and Human Services – Governing Board Handbook and orientation material upon their appointment to serve on the Governing Board.

The orientation material may consist of:

- Governing Board Mission Statement
- Authority of the Governing Board
- Governing Board Roster of Member and their Terms of Office
- Minutes
- Governing Board Bylaws
- General Statutes Applicable to the Governing Board

- Governing Board Policies
- Existing Governing Board Rules
- Department Organizational Chart
- Department Telephone List
- Rockingham County Directory
- Department Service Listing
- Copy of current/last State of the County Health Report
- Copy of current/last Community Health Assessment
- Governing Board Role in a Disaster
- Current Rockingham County Department of Health and Human Services Emergency-Disaster Listing
- Summary of Services

O. The Governing Board will establish methods and guidelines to be followed in the formulation and implementation of policies. These policies will be implemented to ensure compliance of services. The Governing Board will enact policies to support the development, implementation, and evaluation of the Rockingham County Department of Health and Human Services' programs and services.

P. The Governing Board requests that the Health Director present all matters requiring policy guidance by the board in written form. The primary responsibility for initiating policy actions rests with the Governing Board members**,** Human Services Director**,** and the Health Director.

Q. Development: The following guidelines will be followed by the Governing Board in carrying out its responsibility for policy planning:

1. All potential issues, problems, concerns likely to require policy determination will be referred to the Health Director.

2. The Health Director will make an initial determination of whether an applicable policy exists: whether current policy is ambiguous; whether current policy is incomplete or absent.

3. The Health Director will consider whether the issue, problem, or concern warrants policy determination at the present time.

4. Should it be determined either by the Health Director or the Board that policy guidance is necessary, then the Health Director will take the initiative to draft policy alternatives as well as his recommended policy.

R. Except in a case of an emergency, the Governing Board will follow the following steps in approving policy:

1. Draft policy presented in written format as a consideration item at a Board meeting.

2. At the next scheduled Governing Board meeting the draft policy is presented as an action item for the board.

3. During the accreditation process when the volume of policies to be reviewed significantly increases, some Board members will meet with the Director of Nursing to review the policies. After the Board members review the policies, they will present the policies to the Board for approval. These members act as liaisons between Rockingham County Department of Health and Human Services and the Governing Board**.**

S. The Human Services Director and Health Director are responsible for implementing the policies of the Board.

T. The Board shall review the list of policies and update each policy annually or as needed.

U. The Board has final responsibility for the establishment of Governing Board policy.

V. The Governing Board is involved with the Agency's annual review of the Strategic Plan, and establishes their collaboration in identifying the community's needs and setting priorities. This effort evaluates the department's services, the Governing Board's involvement in adhering to current rules, regulations, developing and establishing additional rules, regulations, or ordinances to protect the citizens of Rockingham County, and presenting them to elected officials in order to implement and enforce these activities.

W. The Governing Board enacts policies that promote public health partnership activities, diagnosing, investigating, and/or responding to public health threats and emergencies through community collaboration.

X. The Governing Board strives to ensure that the Rockingham County Department of Health and Human Services follows policies, procedures, guidelines, standing orders, and statutes in providing all services. This process can only be accomplished with licensed, credentialed, and trained staff. Training will be provided upon initial hire and on-going training and continuing education opportunities throughout employment.

Y. The Governing Board reviews reports that identify the community's health and needs. The annual State of Health Report will be reviewed as will the Community Health Assessment to observe all identified needs and to monitor the progress of services being provided by the Rockingham County

Department of Health and Human Services to achieve positive outcomes. The Board advocates for laws and regulations that better enhance and protect the health and safety of the citizens of Rockingham County. The Board may lobby for laws and regulations that require changes. The Governing Board is actively involved in looking at the pros and cons of change and balancing the most efficient and best outcome.

Z. The Governing Board will also assist in ensuring that the community is given the opportunity to become aware of services, changes in services or regulations, and are given the opportunity to participate in and voice their concerns whether positive or negative. The Governing Board will strive to ensure that the Rockingham County Department of Health and Human Services addresses these issues prior to making a definite decision and also interacts with the community to enhance partnerships and improve agency services. Rockingham County Department of Health and Human Services staff may serve on community boards, committee's, etc. as appropriate and with the approval of the Health Director. This is a means of developing collaboration between public health staff and the community.

The Governing Board will support the Rockingham County Department of Health and Human Services efforts in applying for and receiving/ securing grants, funding sources, and approves an annual budget that facilitates implementation and maintenance of the agency's services. Not all services have fees associated; however services that are chargeable are assigned a fee for service. These fees for service are updated as needed, reviewed and approved annually.

AA. The Governing Board may adopt a more stringent rule in an area regulated by the Commission for Health Services or the Environmental Management Commission where, in the opinion of the Board, a more stringent rule is required to protect the public health; otherwise, the rules of the Commission for Health Services or the rules of the Environmental Management Commission shall prevail over local board of health rules. As provided in N.C. G.S. 130A-39, the Board may not adopt a rule concerning the grading, operation, and permitting of food and lodging facilities as listed in Part 6 of Article 8 of Chapter 130A and as defined in G.S. 130A-247(1), and the Board may adopt rules concerning wastewater collection, treatment and disposal system which are not designed to discharge effluent to the land surface or surface waters only in accordance with G.S. 130A-335(c). Rules adopted by the Board shall apply to all municipalities within the Board's jurisdiction. When adopting, amending, or repealing any Board rule, the following process shall occur:

1. Not less than 10 days before the adoption, amendment or repeal of any Board rule, the proposed rule shall be made available at the office of the Rockingham County Clerk and a notice shall be published in a newspaper having general circulation within the area of the Board's jurisdiction.

2. The notice shall contain a statement of the substance of the proposed rule or a description of the subjects and issues involved, the proposed effective date of the rule, and a statement that copies of the proposed rule are available at the Department of Health and Human Services.

3. Board rules shall become effective upon adoption unless a later effective date is specified in the rule.

4. Copies of all Board rules shall be filed with the secretary of the Board.

5. The Board may, in its rules, adopt by reference any code, standard, rule, or regulation which has been adopted by any agency of the state, another state, any agency of the United States or by a generally recognized association. Copies of any material adopted by reference shall be filed with the rules.

2.4	35.1	37.8	39.7
14.2	35.2	38.1	40.1
14.3	36.2	38.2	40.2
31.1	37.1	38.3	40.3
34.1	37.2	39.1	41.1
34.3	37.3	39.2	41.2
34.4	37.4	39.3	41.3
34.5	37.5	39.4	
34.6	37.6	39.5	
34.7	37.7	39.6	

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: WORKFORCE DEVELOPMENT POLICY

DATE DEVELOPED: 10/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18

I. POLICY:

The public health workforce must be prepared to meet the diverse needs posted by a rapidly changing society, facing such issues as emergency response threats, emerging infectious diseases, the explosion of information technology, genetics, managed approaches to care, a renewed emphasis on population focused community systems, a transforming demographic structure, a heightened focus on social determinants of health, improving organizational performance and the need to address racial and ethnic health disparities.

Public health professionals in their roles as environmental health specialists, health educators, and health care professionals can work together in a collaborative effort to reduce disease and prevent deaths.

Public health is experiencing difficulty in recruitment and hiring as well as retention of licensed/credentialed individuals that are well trained within the public health workforce. With the increased healthcare worker shortage, and the competitive public health salaries, it is becoming increasingly difficult to retain qualified and trained individuals to provide the essential public health services that are needed. As the need for services increases the state and local flexibility and resources to address compensation and the workplace environment to remain competitive in recruitment and retention are lacking.

Rockingham County Department of Health and Human Services (RCDHHS) serves a county population of approximately 91,393 with many diverse health care and health promotion needs.

Rockingham County Division of Public Health Services include: Environmental Health; Pharmacy Services; WIC/Nutrition Services; Dental Health; Health Education; Public Health Preparedness; Health Promotion and Disease Prevention Services through Nursing Programs such as Immunizations, Screening for Chronic Diseases, Glaucoma Screening, Lab Services, Adult Primary Care, Pediatric Primary Care, Child Health, Breast and Cervical Cancer Screening, Family Care Coordination Services that includes Newborn Home Visiting/Postpartum, Child Service Coordination, Pregnancy Care Management; Women's Preventive Health Services to include Family Planning and STD's and Communicable Disease investigations and tracking.

II. PURPOSE:

The workforce plan provides a base for assessing the community as a whole, identifying the needs of the community, projecting an annual strategic plan, then directing the workforce so that the public health functions are put into place to provide the services of the health department in a timely and effective manner.

The workforce plan matches the public health team and services to the county, state, and federal resources so that positive outcomes are achieved.

THE ROCKINGHAM COUNTY DIVISION OF PUBLIC HEALTH SERVICES OVERVIEW:

The Rockingham County Division of Public Health Services (RCDPHS) is focused on protecting and promoting the health of the citizens of Rockingham County. As a public health agency, RCDPHS monitors Rockingham County's health status to identify and solve community health problems. Additionally, RCDPHS enforces state and local public health laws and regulations that protect health and assure safety.

Through collaboration of the Rockingham County Division of Public Health Services and partnerships with community agencies, human service agencies, local hospitals, health care providers, churches, and community groups, together as a community we can all improve the health status of our citizens and make Rockingham County a better place to live, work, and raise our families.

The Rockingham County Division of Public Health Services does not discriminate toward clients or employees based on age, sex, color, race, religion, creed, political affiliation, physical handicap, or national origin.

THE OBJECTIVES OF THE SERVICES PROVIDED THROUGH THE ROCKINGHAM COUNTY DIVISION OF PUBLIC HEALTH SERVICES:

A. Recruit and retain a qualified and diverse workforce that encompasses Rockingham County's Communities and the workforces' ability to identify health priorities.

B. Develop education and training strategies that will:

   1. Lead to competency in the essential public health services and address the findings that the workforce has identified as most needed in the areas of analysis, communication, policy development, cultural sensitivity, basic public health science, leadership, quality and systems thinking, and information management.

2. Acknowledge the inherent diversity and levels of specialization in the discipline of public health.

3. Provide continuous educational opportunities and include relevant updating.

C. Create a workplace environment, which:

1. Promotes accountability, commitment to the communities served, pride in individual and team contribution to public health, engages all staff in continuous learning, and promotes cultural competency.

2. Recognizes staff members as "customers", in the same manner the agency wishes staff members to address, support, and engage the community customers of public health services.

D. Develop a systematic approach to workforce development which is comprehensive and proactive to meet the dynamic needs of the workforce and communities served.

E. Develop an infrastructure to provide individual training assessment and planning, monitoring, and reporting of agency-wide training, and resource utilization.

F. Have leverage of local, state, and academic resources to provide integrated approaches and resource use, including exploration of distance learning and use of technology. There will be an annual inventory and evaluation of hardware/software used within the department with recommendations from Information Technology (IT) for replacements or upgrades. Recommendations will be reflected in the annual budget process.

THE ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES INFRASTRUCTURE AND ACCOUNTABILITY:

1. GOVERNING BOARD works with The Board of County Commissioners and the State to identify the resources required for a competent workforce that are appropriate and provide quality public health services.

2 HEALTH DIRECTOR is responsible to the Human Services Director for workforce strategy, priority setting, and development of a productive and cohesive work environment. The Health Director ensures a comprehensive agency orientation for all new employees, and required training thereafter.

3. DIRECTOR OF NURSING is responsible to the Health Director for the Nursing workforce and the supervision of nursing practice. The Director of Nursing will strive to create and maintain an expert public health workforce by focusing locally within divisions, on assessment of development needs, individual training plans and reporting. The Director of Nursing assists mentors, coaches, and trains nursing supervisors in appropriate training resources including programs, online options, hands-on practicum and facilitates the development of in-service training programs as defined by the divisions needs. The Director of Nursing is responsible for ensuring that staff have and maintain appropriate licensures and credentials. The Director of Nursing tracks staff certification and licensure.

   The remaining management team and department supervisors/ directors consist of the following:

   - Accounting Specialist
   - Management Support Supervisor
   - Environmental Health Director
   - WIC/Nutrition Program Supervisor
   - Pharmacy Manager
   - Health Education Program Manager
   - Clinical Nursing Supervisor
   - Family Care Coordination Supervisor
   - IT Business Analyst

4. The management team and department supervisors/directors collectively set priorities for the workforce development and creation of the workplace environment. These managers recruit, hire, assure on-going credentialing, manage, and support professional growth. The managers also support a system of workforce assessment and resource management through each department manager and an agency wide reporting process.

5. The Rockingham County Department of Health and Human Services works in conjunction with Rockingham County Human Resources for recruitment, qualification, and selection of candidates. Each department manager reviews and revises job descriptions annually as needed, during the time of the employee's performance evaluation.

6. The Rockingham County Division of Public Health Services provides a comprehensive orientation to the department and within each work unit for all staff. Each manager focuses on assessment of development needs, individual training plans, and reporting. The managers report to and collaborate with the Health Director and the Director of Nursing on workforce issues. The managers plan and coordinate the orientation of all new employees within their

departments, and on-going annual training. The managers assist, mentor, and train staff members in finding and completing appropriate training through formal programs, online programs, and hands on practicum through teaching and return demonstration. The managers also facilitate the development of in-service training programs.

7. The Rockingham County Division of Public Health Services staff members are responsible for ongoing professional growth and skill development to meet changing public health priorities. The agency will provide the structure, resources as available, and support to individual and discipline development.

ROCKINGHAM COUNTY NEW EMPLOYEE ORIENTATION PROCESS:

The Rockingham County Human Resources Department qualifies initial applicants for positions, provides consultation to the management team and staff regarding state and county Personnel Policy and Procedure, manages all personnel records, and provides annual job performance evaluation forms. The new employee orientation consists of personnel information and instructions for driving and work place safety. The departmental manager will then provide an orientation into the work setting of the new employee. The Rockingham County Human Resources Department provides initial technical orientation to county policies and procedures. This orientation is followed by a health department general orientation. The new employee will then receive an orientation into the department in which they are assigned. Each department has an identified orientation process with time limit established. It is the intent of the Rockingham County Division of Public Health Services to ensure the understanding and return demonstration of practices prior to the employee providing services independently.

ROCKINGHAM COUNTY DIVISION OF PUBLIC HEALTH SERVICES PERFORMANCE EVALUATION:

1. The purposes of the Employee Performance Evaluation are as follows:

    a. To provide a systematic methodology and technique by which management may determine increases in an employee's pay based upon a pay for performance criterion.
    b. To provide a systematic methodology and technique by which management can guide, direct and record the progress of an employee's performance with respect to employee development.

c. To provide a systematic methodology and technique by which management can guide, direct and record the progress of an employee's performance with respect to discipline action.
d. To provide a systematic methodology and technique by which managers can reinforce desirable behavior or extinguish undesirable behavior on the part of the employee.

2. Steps in preparing performance evaluations for agency staff are as follows:
<u>Administration</u>

a. Prepare an orientation package for the supervisor.
b. Retrieve the employee's personnel file, verify if employee is due a systematic increase, or to establish probation to permanent status with the agency.
c. Compose a memo to the supervisor referencing the employee's annual performance evaluation, systematic increase, or to alert the supervisor of the six to nine months probation to permanent status. Advise the supervisor of the criteria for the employee's eligibility for a systematic increase, and the requested date for all information to be returned to the Personnel Technician.
d. All evaluations will follow the County NeoGov electronic process.
e. Attach a copy of the employee's current job description which is printed from the Personnel Assistant's computer file. The Personnel Assistant compares the printed job description to the hard copy in the filing cabinet to ensure that both are the same. The supervisor should review the job description with the employee during the appraisal to determine if any additions or deletions to the employee's duties and responsibilities should be included. All changes should be noted on the job description and returned to the Personnel Assistant along with the completed performance evaluation from the supervisor. The Personnel Assistant should, in turn, update the job description and forward to the supervisor to review. Upon approval by the supervisor, the job description is filed in the agency's Job Descriptions file cabinet. This information is filed in order by Job Classification and Position Number.
f. Include the annual Confidentiality Statement, and the Rockingham County Policy for Computer Use, for the supervisor to request employee read and sign.
g. Place the orientation package in a 9 X 12 brown envelope.

Seal securely with tape. Address the envelope to the appropriate supervisor, and personally deliver to the supervisor, or place in their office chair for immediate attention.

Supervisor or Director:

a. The supervisor or immediate supervising director of the employee will receive the packet with the consent forms and job description.
b. The supervisor or immediate supervising director will give the job description to the employee to review and update and return to the supervisor by the performance evaluation date. The updated job description will be returned to the Personnel Technician for updating.
c. Upon completion of the performance evaluation from all parties, the supervisor/director will review the evaluation with the employee. A copy printed from the NeoGov system will be printed and returned to the Personnel Technician.
d. The performance evaluation should reflect the employee's performance for the year, not just an isolated event. The supervisor/supervising director should make entries into the NeoGov system throughout the year detailing positive comments as well as negative comments that should be reflected on the employee's performance evaluation.

All non-supervisory staff is evaluated on the following elements:

- Knowledge of Job
- Quality of Work
- Quantity of Work
- Dependability
- Attendance
- Initiative and Enthusiasm
- Judgment
- Cooperation
- Relationship with others
- Coordination of Work
- Safety and Housekeeping

Supervisory staff has the following additional elements:

- Planning
- Organizing
- Staffing

- Leading
- Controlling
- Delegating
- Decision Making
- Creativity
- Employees Relations
- Policy Implementation
- Policy Formulation

G. COMMITTEES ESTABLISHED WITHIN THE ROCKINGHAM COUNTY DIVISION OF PUBLIC HEALTH SERVICES ARE:

1. Limited English Proficiency Committee - This committee will strive to ensure compliance of communication efforts among the non-English speaking population within the county. This committee strives to assure that information disseminated about the agency and its services appropriately reflect the cultural and linguistic character of the local population and is accessible to special populations. This committee will strive to ensure that forms, consents, signage, interpretation is available for non-English speaking clients presenting to the Rockingham County Department of Public Health for services.

   This committee will strive to ensure that staff receives training in cultural sensitivity and/or cultural competency. This committee will recommend ways to communicate more effectively with clients through all departmental divisions. The committee will assist the agency with:
   - Improving the work environment
   - Assessing the impact of policies on staff roles and environment
   - Gathering client and staff input through client and employee surveys
   - Specific trainings on cultural diversity and teamwork
   - Providing a direct link for staff feedback to the Management Team regarding staff issues including training needs, recruitment and retention, and promoting staff interaction and team building

2. Quality Improvement Council - This committee will strive to ensure that the Rockingham County Department of Health and Human Services maintains the highest standards of ethical conduct and fair dealing, and compliance of all applicable legal and regulatory requirements. This committee will provide direction, and oversight for the implementation of the quality improvement initiatives. This committee will strive to ensure that the Rockingham County Department of Health and Human Services will utilize an on going,

planned, systematic and objective performance assessment and improvement plan in order to continuously strive to improve the quality of care and services to the agency's clients and meet the needs and expectations of its internal and external customers.

3. Safety Committee - This committee will promote the well-being and independence of the client and family unit and provide comprehensive health services in the home environment, as well as agency setting. This committee will enforce all rules and regulations, be alert for unsafe practices and take appropriate action to correct any irregularities. This committee will assist the department to design a safety plan that will minimize hazards related to the delivery of agency services. This committee will ensure appropriate training of staff for safety codes, evacuations, and emergency preparedness, as well as prevention of accidents and injury to the agency's employees and clients. Each employee is responsible for identifying work place hazards and promptly informing the safety committee of these issues.

4. EHR Team - This committee assists with all clinical and dental electronic record issues throughout RCDPH. They are also the liaison with vendor systems and technical support entities. They implement new hardware and software to improve workflow. They ensure all HIPAA standards are followed and client information is secure. The team provides in-house technical support and troubleshooting techniques to staff. It is comprised of clinical, IT, and administrative staff.

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3.1	32.1
3.2	32.2
9.6	32.3
26.3	32.4
31.6	

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

CARE MANAGEMENT FOR AT RISK CHILDREN

SECTION	**POLICY NO.**
Care Management For At Risk Children	CMARC-1

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CARE MANAGEMENT FOR AT RISK CHILDREN (CMARC)

DATE DEVELOPED: 5/11
REVIWED: 6/16; 6/17; 6/18; 6/19; 11/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/18; 6/19; 11/19; 6/20; 6/21; 6/22; 6/23; 6/24

I. POLICY:

The Care Management for At Risk Children (CMARC) program is care management for:

- Children with special health care needs;
- Babies who were in a Neonatal Intensive Care Unit (NICU);
- Children in foster care; and
- Children that are exposed to toxic stress in early childhood or adversely affected by social determinants of health.
- Children identified as priority by their Medicaid pre-paid health plan (PHP).

II. PURPOSE:

The goal of CMARC services is to provide children and families with linkage to services that will improve the child's care and meet the needs of children and families. Services should be provided as outlined in CMARC program policies. These polices may be reviewed in the CMARC Tool Kit.

III. GUIDELINES:

A. Eligibility:

There are no financial eligibility criteria for CMARC. Eligible infants and children may be identified from age birth to 5. Risk conditions and diagnoses used to identify children are listed in Section I of this Policy. CMARC services are offered to children who receive Medicaid, private insurance or who have no insurance source.

B. Recruitment:

Children are identified for the CMARC program through the following methods:

- Direct provider referrals;
- Social service agency referrals (e.g. Women, Infants and Children [WIC], DSS, community programs);
- Hospital/inpatient referrals;
- Direct referral by enrollees or families; and

- Risk stratification and other data-based identification methods.
- Referral directly from Medicaid PHP

1. Outreach

   a. Educate patients, medical homes and community organizations about the benefits of the CMARC Program and target populations for referral. Disseminate the CMARC Referral Form electronically and/or in a paper version to potential referral sources.
   b. Contact patients identified as being priority through the Virtual Health (VH) Queue, CMARC Priority Population, their Medicaid PHP**,** or through a CMARC referral form.
   c. Develop a list of community resources available to meet the specific needs of the population as a locally-developed resource manual.

2. Population Identification

   a. Use CareImpact to identify the priority population. (CareImpact is a data visualization tool used by CMARC supervisors and care managers that provides operational reports, utilization patterns and data, and care opportunities for the defined population.) Follow guidance in the CMARC Tool Kit for working this population in order to employ strategies that have the greatest potential to optimize health, promote wellness and improve health outcomes while improving the quality of care provided and reducing health care cost.
   b. Collaborate with Medicaid PHPs to facilitate services for priority children.
   c. Collaborate with out-of-county CMARC Care Managers to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.

C. Hours of Operation: Normal hours of operation are Monday through Friday, 8:00 a.m. to 5:00 p.m. Exceptions are county recognized holidays and county closings for adverse weather. Scheduling may be necessary after 5 p.m. or weekends to accommodate families with the supervisor's awareness or in time of disaster or a public health emergency.

D. The CMARC CM will:

1. Meet with the CMARC supervisor as needed to be made aware of updates in the program. The CMARC Program Manager will assign

clients to the CMARC CM as referrals are received. These assignments will be completed in Virtual Health (VH). Case manager will be changed upon family or case manager request if conflict of interest arises and will be noted in VH.

2. Follow guidelines in the CMARC Care Management Standardized Plan and Local Health Department processes for optimal impact on CMARC priority populations.

3. The CMARC supervisor will assess caseload for quantity and intensity levels. There will be no waiting list. Risk stratification will be used to determine the services needed.

4. The care manager is expected to make a minimum of 3 attempts to engage the guardian in care management over the first 7 business days. These attempts should occur on different days at different times and different ways. If the care manager is unable to engage the guardian with a signed care plan in 30 days, the care manager should evaluate the need for further effort to engage the family based upon the needs of the client. Patient-centered methods of contacting the family include but are not limited to:

   - Phone call
   - Home visit
   - Clinic or medical home face-to-face encounter
   - An attempted home visit must be made prior to closure.

5. When the care manager contacts a new referral, they will talk with the family using motivational interviewing skills to determine whether the child and family could benefit from care management services. If the child is enrolled, the care manager will assess the child's health and family needs, involve family in decision-making process to develop a patient-centric plan of care, and work with the family to assure that the child has a medical home for ongoing health care. Enrolled CMARC clients should be placed in a managed CMARC episode and appropriate engagement level set. Care Manager will develop tasks and intervention appropriate for referral reason and/or assessment results according to CMARC guidance documents. Each child engaged in the CMARC Program shall have an established care plan that has been signed by the care manager and agreed upon with the guardian within 30 days of engagement in CMARC (managed).

6. Claims should be reviewed during the initial assessment and ideally prior to every contact with the parent/caregiver/ guardian. Review of the claims should be done at a minimum of every 90 days for as long as the child remains in care management.

7. Records:

   a. Comprehensive Needs Assessment (CNA) completed within 30 days of placing client in engaged status and updated at each contact but a minimum of every **30 days**.

   b. Life Skills Progression (LSP) completed initially within 60 days of active engagement in CMARC services and every six months for children with a toxic stress risk factor. LSP should be completed in the home or in a face-to-face setting. If it is not possible to complete this screening in the home or face-to-face with the parent or guardian, documentation should be added in the client's interaction describing the inability to complete the screening. This assessment is required for all referrals with toxic stress indicators. It may also be used with other target populations at the case manager's discretion. The LSP is used to document and address family progress.

   c. The Survey of Well-being for Young Children (SWYC) should be completed within 30 days of placing the child in high, medium, or low engagement level and should be completed in the home or in a face-to-face setting. If it is not possible to complete this screening in the home or face-to-face with the parent or guardian, documentation should be added in the client's interaction describing the inability to complete the screening in an alternate venue. All appropriate components of SWYC should be completed.

      The child's adjusted age should be used to determine the appropriate screening periodicity and form. For children under 2 months of adjusted age, on the parent concerns, emotional changes with a new baby and family questions should be used.

      The SWYC should be repeated based upon the tool periodicity schedule as long as the child remains in care management. If a need is identified, the need should be included in the care plan, and should continue to be addressed within the care plan until the need is resolved, adequate services are in place to address the need or the caregiver indicates they are not interested in addressing the need. SWYC results should be shared with the child's primary care provider.

   d. Will use VH to document all pertinent information including all contacts, attempted contacts, referrals, assessments (CNA, SWYC**,** and/or LSP), collaborative contacts, care plans that include goals with specific measurable outcomes

and as appropriate CMARC program case manager name and case status. Documentation of all client contacts should be completed within 72 hours of contact.

e. Develop Patient Centered Care Plans and document with needs identified based on LSP, CNA, SWYC. Care plans will include goals and expected outcomes.

8. Care management status will be assigned to patient/client by CMARC CM to determine follow-up/intensity/frequency of visits/services needed. Status levels are set based on family need and willingness to engage in services.

   a. High - daily to weekly engagement with the member/ caregiver (at least every 7 days).
   b. Medium - weekly to bi-weekly engagement with the member/caregiver.
   c. Low - bi-weekly to monthly engagement with member/ caregiver (at least every 30 days).
   d. Pending/**Referred** - newly identified client assigned to CMARC CM awaiting screening. This status should not exceed 30 days.
      Patients with extended hospital stays (i.e., NICU, severe trauma, etc.) may stay in pending longer than 30 days or status may be updated.
   f. Response to all referral sources (unless source requests this not occur) should occur in writing:

      (1) Regarding receipt of referral within 72 business hours; and
      (2) Regarding outcome of referral as soon as possible, but no later than 30 days unless a referral source specifically requests that this not happen.
      (3) The CMARC care manager should notify the medical home in writing if the parent or guardian refused, declined CMARC services, or when the CMARC care manager is unable to contact.
      (4) The CMARC care manager should notify the medical home when the child is closed to CMARC services and are no longer being care managed and should include the reason for closing the episode of care.

9. Interactions may take place through face-to-face contacts**,** video conferencing, or phone calls to achieve care plan goals. Video conferencing may be used with patient consent and through a secure platform. Case Manager should prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community

visit, etc.) over telephone interactions for children in active case status, when possible. All contacts should be made in a private and HIPPA compliant manner. Texting may be used with prior consent of the patient. Texting must not contain any protected health information and is not used in place of an approved patient-centered interaction (i.e., face-to-face, phone call, or video conference).

10. Contacts must be made based on engagement level or sooner if family needs. The child service coordinators must:

    a. Review and update the care coordination plan and goals with the family. Assess whether interventions are reaching goal(s) and if not, determine if revisions are needed or if deferral should be considered.
    b. Determine whether there are new situations or concerns to be added to the plan.
    c. Update CNA **at least every 30 days**, **care plans at least every 30 days,** LSP at least every 6 months **(**if required for risk factor) and SWYC based on periodicy schedule.
    d. Make referrals as appropriate to medical, developmental/ educational, and other community resources.
    e. Record interaction in VH interaction tracker.

11. The CMARC CM will inform families on the importance of having a Primary Medical Home and receiving preventive health care and assist them in accessing these services. Preventative health services may include, but are not limited, to well child physicals, nutrition, dental health, development, immunizations, and other clinical services. Case Manager will assess and follow-up on Care Alerts to assure child's receipt of appropriate preventive and primary care services in collaboration with medical home staff.

12. The CMARC CM will assess the following elements: Family status and home environment; medical/behavioral/dental health status; social supports; financial needs; family demands, relationships, and functioning (LSP); cultural beliefs and values; strengths/assets of child/youth, family caregivers; and current goals of the child and family.

13. Assist with transfer of families to new service coordination agency when appropriate and document within the client record according to guidelines.

14. Maintain confidentiality on all CMARC clients per HIPAA policies. The Case Manager will determine what information can be released and what sensitive information must be redacted without another individual's consent for its release.

E. Closure to Care Coordination for Children Program:

Children enrolled in CMARC will have documentation of and their families will receive assistance regarding deferral in the CMARC program when indicated.

1. Upon receipt of CMARC referral, the CMARC CM will attempt at least 3 contacts with the patient/guardian by telephone or face-to-face encounter within seven (7) business days. If unable to make contact with the client in **5 attempts** over 30 days either by phone calls or face-to-face, the CMARC will close the pending referral and notify PCP and/or referral source. The child should be closed as unable to reach (UTR). A face-to-face attempted contact should be attempted before closure.

2. For engaged CMARC children, the CMARC CM should continually assess whether interventions are reaching the desired goal(s) and if progress is not being made, determine whether revisions (Tasks, Interventions, and/or Goals) are needed, or whether deferral should be considered. If care manager is unable to contact/reach families after **at least 5** attempts by phone calls or face-to-face, the child should be closed as lost to contact. A face-to-face attempted contact should be attempted before closure.

F. Integration with Health Care Provider

1. Establish, maintain and seek to improve relationships with primary care provider staff and primary care providers.

2. Collaborate with medical home PCP/care team to facilitate implementation of patient-centered plans and goals targeted to meet individual child's needs.

3. Work with medical homes to assure smooth transitions among and across care settings as needed (e.g., hospital to community) and to develop action-oriented care plans as appropriate (including self-management skill building).

4. Ensure that changes in case status, follow through with plan of care and other relevant updates (especially during periods of transition) are communicated to the medical home PCP and/or care team. The frequency and methods for sharing updates should be based on each practice's wishes which have been documented for future reference.

5. Ensure families/children are well-linked to their medical homes. Provide education about the importance of the medical home.

Assist with appointment scheduling, transportation, preparing for appointments, and accompanying patients to appointments, as needed.

6. Assess and follow up on patient's receipt of needed clinical services.

G. Collaboration with Medicaid PHPs

1. Encourage CMARC care managers to work with the PHPs as a strong, collaborative team with clearly delineated roles/ responsibilities.

2. Maintain the caseloads for optimal impact of priority populations demonstrating the care manager's commitment towards the Local Health Department's ability to achieve program wide goals of improved access, quality and contained cost through effective utilization of services.

3. Monitor CMARC Performance Measures and related reports to track progress.

H. Improving Organizational Performance:

The health department shall monitor local CMARC records for Quality assurance and appropriate documentation. Monitoring will occur on an ongoing basis using reports within VH and Care Impact. Chart review tool will be completed on a quarterly basis. These can be completed by supervisor or peers.

I. Training:

1. Participate in CMARC sponsored webinars, trainings and continuing education opportunities (New Hire Orientation, CMARC Webinars, Content-Specific Trainings) to enhance skills, knowledge and abilities.

2. Participate in State/Local Health Department-sponsored meetings, training/continuing education and mentoring opportunities to share program updates, best practices and develop standardized processes for accomplishing program goals.

3. Pursue ongoing continuing education opportunities to stay current in evidence-based care management high risk children.

4. Develop and continually practice Motivational Interviewing techniques to enhance MI skills.

5. Develop population management skills including knowledge and experience required to strategically work lists provided through VH.

J. Civil Rights:

1. The CMARC Program is provided solely on a voluntary basis and individuals are not coerced to receive a particular service.

2. Acceptance of the CMARC Program is not a prerequisite to eligibility for or receipt of any other program/service involvement or benefits.

3. These services and care will be provided without regard to grounds of race, color, age, religion, creed, sex, political affiliation, national origin, or physical handicap status will be denied benefits or services.

K. Staffing:

1. Employ care managers meeting CMARC care coordination competencies with at least one of the following qualifications:

- Registered nurses;
- Social workers with a:

  - **Bachelor of Social Work (BSW, BA in SW, or BS in SW) or Master of Social Work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education (CSWE) accredited social work degree program; or**

  - **Bachelors Degree in a human service field with 3 or more years of care management/case management experience working with the specific population (low income, pregnant individuals and/or children ages 0-5 years) and has certification as a Case Manager (CCM preferred); or**

  - **Bachelors Degree in a human service field with 5 or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children ages 0-5 years.**

2. Supervisors who carry a caseload must also meet the CMARC care management competencies and staffing qualifications.

3. The team of CMARC care managers shall include both registered nurses and social workers in order to best meet the needs of the target population with medical and psychosocial risk factors. If a team of CMARC care managers represent only one professional

discipline (nursing or social work) the agency must seek to hire individuals of the other discipline when making hiring decisions.

4. Engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high risk children. This skill mix must reflect the capacity to address the needs of patients with both medically and socially complex conditions. Staffing decisions must reflect an effort to achieve a balance of nursing and social work skills among program staff.

5. CMARC Care Managers must demonstrate:

    a. Proficiency with the technologies required to perform care management functions, particularly as pertains to utilization of VH and CareImpact;
    b. Motivational interviewing skills and knowledge of adult teaching and learning principles;
    c. Ability to effectively communicate with families and providers; and
    d. Critical thinking skills, clinical judgment and problem-solving abilities.

6. CMARC Supervisor should provide qualified supervision and support for CMARC care managers to ensure that all activities are designed to meet performance measures, with supervision to include:

    a. Provision of program updates to care managers;
    b. Daily availability for case consultation and caseload oversight;
    c. Regular meetings with direct service care management staff;
    d. Utilization of monthly and on-demand VH reports to actively assess individual care manager performance;
    e. Assure compliance with expectations found in the CMARC Supervision Guidance Document, i.e., review of care manager documentation, utilization of VH reports, etc.;
    f. Maintain services during the event of an extended vacancy and complete a contingency plan to the network that describes how vacancy will be covered and plan for hiring, if applicable; and
    g. Notify Division of Child and Family Well-Being Whole Child Health Section Regional Child Health Nursing Consultant when local health department staff meets with local network staff regarding CMARC services.

L. Performance Measures/Reporting Requirements:

1. The local health department shall engage in activities that will result in the performance measures (metrics) listed below being met for all CMARC clients.

   a. Utilization (Penetration) Rate: Regardless of Medicaid status, at least 1.85% of members ages 0-5 who are receiving CMARC care management services.
   b. Outreach and Engagement: At least 85% of members referred for care management will have a completed care management encounter with member or 3 more attempted encounters within 7 business days of referral.
   c. Active Care Management: At least 85% of members engaged in care management will have a signed care plan within 30 days of enrollment in CMARC services.
   d. Well-Child Visits in the First 30 Months of Life: The rate of well-child visits for children ages 0-30 months for all members enrolled into CMARC services in the reported year.
   e. Child and Adolescent Well Visits: The rate of well-child visits for children ages 3-5 years of age for all members enrolled into CMARC services in the reported year.
   f. Childhood Immunization Status (Combo 10): The percentage of children 2 years of age who received the recommended vaccinations for all members enrolled into CMARC services in the reported year.

2. Reporting Requirements:

   The local health department shall adhere to the following reporting requirements:

   - All client information and program services are to be electronically documented in VH within 72 business hours of service provision, in accordance with local health department policy. Data for all performance measures listed above will be evidenced by data reported into VH/CareImpact.

M. Performance Monitoring and Quality Assurance:

1. Performance Monitoring: The Children and Youth Branch shall monitor the LHD by:

   a. Conducting an annual CMARC Program Review via video conferencing, on site, or phone.

b. Reviewing VH/CareImpact Client Management System Reports each month.
c. Working with the LHD staff to regularly (at least once per quarter) assess the CMARC Performance Measures for the county. If the results are less than desired, Division of Child and Family Well-Being Whole Child Health Section will provide technical assistance to LHD's CMARC staff. The regional child health nurse consultant will assist in developing effective strategies to improve results and avoid the corrective action plan (CAP).

2. Quality Assurance:

a. The Division of Health Benefits will also be monitoring the performance of the LHD. If the DHB determines that the LHD is underperforming, the DHB will issue a CAP to the LHD and will notify the Division of Child and Family Well-Being Whole Child Health Section within 72 hours (via BCM021 document) about it.
b. The CAP is explained and will be implemented according to the Division of Health Benefits' Program Guide Management of High-Risk Pregnancies and At-Risk Children. (It is found in the CMARC Toolkit.)
c. Not meeting performance measures by failing to provide appropriate services may result in a reduction of funds.

IV. FUNDING GUIDELINES OR RESTRICTIONS:

A. Funds shall be used to support CMARC services, which include, but are not limited to:

1. Completion of Life Skills Progression on all children receiving care management through CMARC who are referred for toxic stress (as identified in the Toxic Stress Section of the CMARC Referral Form or by others making referrals by phone or through VH to CMARC for that reason). The CMARC care manager may also choose to utilize the LSP for other children/ families, as appropriate. When the CMARC care manager determines that the use of the LSP assessment is appropriate, the LSP will be completed on entry into the system and every six months thereafter and/or upon discharge.

2. Completion of the CNA phone or face-to-face contact.

3. Provision and documentation of activities.

4. Determination of the Case Status for ongoing CMARC services; service engagement levels and goal(s) (in VH) shall be reviewed and updated at a minimum of every 30 days for clients being care managed at high, medium, or low engagement levels in accordance with the CMARC Standardized Plan.

B. Funds cannot be used to provide case management services for children 5 years and older.

C. Funds in the amount of 1/12 of the annual allocation for non-Medicaid CMARC services shall be drawn down each month for the first six months to support CMARC services for the designated number of non-Medicaid children to be served. The LHDs should then ascertain the number of children actually served in those six months. If there are concerns that an adequate number of non-Medicaid children may not be served, then the LHD shall decrease the amount of allocation drawn down accordingly for the remaining six months.

Funds can only be used to support the non-Medicaid children seen for care management. To spend funds in any other way requires prior approval from the CMARC Program Manager.

Non-Medicaid CMARC funds cannot be used to supplement services for CMARC Medicaid children funded through the per-member-per-month contract.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

CHILD HEALTH PROGRAM
INDEX

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: **CHILD HEALTH**

DATE DEVELOPED: **5/96**
REVIEWED: **1/17; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 1/23; 6/23; 6/24**
REVISED: **1/17; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 1/23; 6/23; 6/24**

I. POLICY:

The Division of Public Health Services will provide health services to children to maintain healthiness, prevention of illness, early detection, referral, and anticipatory guidance.

II. PURPOSE:

To provide preventative health services through screening, diagnosis, treatment, referral, and follow-up of medically indigent children in Rockingham County.

A. Children birth through 20 years of age will be screened in clinics to:

1. Reduce mortality and morbidity among children and youth resulting from communicable disease, injuries (intentional and unintentional) and other preventable conditions.

2. Promote healthy behaviors.

3. Support optimal physical, social and emotional health of children and youth.

B. The Division of Public Health Services shall provide, contract for the provision of, or certify the availability of child health services for all individuals within the jurisdiction of the Division of Public Health Services.

NC Administrative Rules 10A NCAC 46.0204

The Division of Public Health Services shall establish, implement, and maintain written policies that include the following:

1. A description of the procedures for child health services that are provided.

   a. Child health information, referral, immunizations, and hemoglobinopathy screening upon request.
   b. Follow-up of infants with conditions identified through newborn metabolic screening (e.g., PKU, hypothyroidism) upon request or as needed.

c. Routine periodic well-child preventative care to children 0-20 years of age through one or more of the following mechanisms:

* initial and interim health history;
* comprehensive exam and laboratory services;
* developmental evaluation;
* nutrition assessment;
* counseling, including anticipatory guidance; and
* referral for further diagnosis and treatment.

2. A description of the target population for child health services provided by the local health department, including eligibility criteria. The local health department shall emphasize provision of child health services to individuals who would not otherwise have access to these services.

3. A description of fees, if any, for child health services provided by the local health department.

C. The Division of Public Health Services shall establish, implement, and maintain written policies for the provision of community and client child health education services within the jurisdiction of the local health department. The policies shall include a description of the procedures for provision of services for identification of, recruitment of, and outreach to the target population.

III. GUIDELINES:

A. Child Health Nurses will provide follow-up for children enrolled in the Child Health Program as appropriate. Child Health Nurses will coordinate and refer clients for all needed services during a visit (e.g., immunizations, family planning, maternal health, and WIC).

B. The Division of Public Health Services has in place case management for follow-up on referrals and missed appointments through Community Care of North Carolina.

C. Outreach Community Education:

1. RCDHHS uses Bright Future Resources for community outreach education such as the Bright Futures Tool Kit and The Community Guide (https://www.thecommunityguide.org/index.html).

2. RCDHHS has the following mechanisms in place for the recruitment of clients. The Division of Public Health Services' website offers a complete guide to services for the general

population. Brochures for Child Health Services are distributed to the community and clients are educated about the program by our Care Management for At Risk Children (CMARC)/Care Management for High Risk Pregnancies (CMHRP) Staff and our postpartum visiting nurse. The Division of Public Health Services also participates in multiple fairs during the year to promote community awareness of services.

The kindergarten and Head Start information given out by Smart Start also contains brochures of available child health services through DHHS. The Division of Public Health Services works closely with Social Services to promote health care for foster/displaced children by way of Child Protective Services referrals and scheduling well child checks for needy children.

3. No person, on the grounds of race, color, age, religion, creed, sex, sexual orientation, political affiliation, national origin, or physical handicap status will be denied services or benefits.

4. Financial Eligibility: All Medicaid recipients (birth – 20 years up to 21st birthday) are eligible for nurse screening clinic. All other children's eligibility will be determined according to Division of Public Health Services' fee schedule.

5. No client will be denied services due to inability to pay. Financial eligibility will be obtained prior to services being rendered. If the client has private insurance, the client/family member will be informed of their options.

    - The client/family member will be informed of the choice to receive these services through their preferred provider and pay the co-pay.
    - The client/family member will be informed that the private insurance carrier will be billed. In the event, the insurance source denies payment, the client will be billed the charges according to the fee schedule.
    - The client/family member will be informed that the Division of Public Health Services will provide services as requested, and their financial responsibilities will be based on their financial eligibility. Charges will be generated according to the current sliding scale fee.

D. Clinic Schedule:

Health Check, Nurse Screening, Kindergarten/Pre-K and Head Start Assessments are offered by appointment. Appointments are made through the Division of Public Health Services' computer system. Every effort is made to coordinate appointments with WIC and immunization schedule.

Appointments are available Monday through Friday between 8 am & 5pm and **5 pm & 7 pm on most Thursdays** of each month.

Physicals may be scheduled within two weeks of the request. The EHR Communicator Application will remind clients of their appointments prior to the appointment date via text message or automated call.

E. Physical Assessments:

Physical Assessments are provided by Child Health Nurse Screeners (see list of CH screeners) and Advanced Practice Providers (APPs). (See recommended schedule of health services for children – Child Health Manual). The Child Health Nurse Screeners will receive 10 hours of program specific training and 100 hours of clinical practice performing Child Health Screenings with a minimum of 50 preventative visits by December 31 of each calendar year. (Hours may be reduced by the State Division of Child and Family Well-Being, Whole Child Health section due to declared state of emergency events on a year-by-year basis.) Each CH Nurse Screener will have an onsite clinical assessment every three years by the Child Health Regional Nurse Consultant (due **2026**).

Children seen in clinics by CH Nurse Screener will receive the following services, regardless of payor, each time they receive a well child visit. A roster of qualified Health Check Registered Nurse Screeners will be maintained in the Child Health Program Manual and kept updated. These Child Health Screeners are responsible for providing and documenting the services listed below for all individuals of receiving well-child services, regardless of pay source.

1. The Child Health Program follows the current NC Health Check Program Guide guidelines which includes the recommended periodicity schedules.

2. An Initial Health History with annual updates at well child visits per Medicaid periodicity schedule as appropriate on subsequent visits:

    a. General contact information: family composition, health problems.
    b. Family medical history.
    c. Eco-Social history – (substance/tobacco abuse, domestic violence).
    d. Perinatal history (at initial visit), including history Group Beta Streptococcus status of mother and treatment prior to delivery for infants birth to six weeks of age. The nurse will screen for status prior to delivery and verify that the mother received appropriate treatment intrapartally. If the mother is unable to relate this information, the nurse will try to contact the delivering hospital for this information.

e. General History Child.
f. Biological Family History.
g. Past History Child.

3. A review of immunizations and updates at all visits. The Child Health Program follows the current CDC and ACIP recommendations and immunization schedules. Immunizations can be given by the well child screener or referred to the immunization clinic, if needed.

4. Unclothed Physical Assessment

a. Blood pressure (three years of age and older)
b. General appearance
c. Skin/nodes
d. Head (scalp and fontanels)
e. Nose
f. Eyes (ocular motility assessment/pupil/red reflex; visual acuity after age 3)
g. Ears (canals/drums); hearing after age 4 years
h. Mouth & pharynx
i. Teeth/gums/oral care
j. Neck
k. Lungs/chest
l. Breast
m. Heart (apical/femoral pulses)
n. Abdomen
o. Genitalia/Tanner Stage
p. Extremities (gait)
q. Back and spine (posture)
r. Hips
s. Neurological system

5. Documentation on Bright Futures Forms

Charting will be by exception of the Bright Futures Age Appropriate Form within the electronic health record (EHR).

a. Comprehensive health history will be performed at the initial evaluation. History is updated every visit in the EHR by the nurse.
b. If child did not keep appointment the nurse will send a letter to the child's parent/legal representative to notify of the missed appointment and the need to reschedule. The letter will be documented in the client's EHR. Depending on the age of the child, a referral can be made to CMARC or CCNC case managers when children have repeated missed appointments.

c. Appropriate educational materials are given to parents focusing on client concerns provided by Bright Futures.
d. Targeted age appropriate anticipatory guidance handouts are provided per Bright Futures.
e. All documentation on the child health physical chart will follow agency clinical records policy and EHR policy. The agency's approved abbreviation list will be used and all disciplines will sign with a minimum of first name initial, last name, and title.
f. All Child Health physical EHR billing will be completed at the time of physical or prior to close of business that same day. Documentation will be completed within 24 hours.
g. If Child Health ERRN is completing a physical and the Advanced Practice Provider (APP) also sees the child on the same day, each provider will complete a separate note in the EHR system. The CHERRN will complete a well child physical note and the APP will complete a sick visit note. The CHERRN will add all billing information into the Electronic Super Bill (ESB) system and paper ESB, but the APP will only add to the paper ESB. Billing personnel will use the paper ESB to manually add both visits together to form one unified electronic claim that will be billed to the insurance carrier. The APP can only bill for services above and beyond those services provided in the well child physical.

6. Physicals will also include:

a. Objective hearing screenings must be performed annually for children ages 4-6 years, at age 8 years, age 10 years, and <u>once</u> between age ranges of 11-14, age ranges 15-17, and age ranges 18-20 years. Screening may be performed at other ages if risk factors are present.
b. Objective vision screenings must be performed at every periodic screening assessment beginning at age 3 years through age 6 years and again at age 8 years, age 10 years, age 12 years and age 15 years. Screening may be performed at other ages if risk factors are present. Vision screener may be used for risk assessment at the 12 month, 24 month, and 3 year to 5 year visits. The vision screener may be used on older children who are non-verbal or who cannot complete an objective vision screen.
c. Age-appropriate developmental surveillance that includes review of history, review of systems, and parental concerns at every well child visit. Developmental surveillance is not required when developmental screening is required.

Developmental screening is requited at the 6 month, 12 month, 18 or 24 month, and the 3, 4, and 5 year well child visits, with a standardized developmental screening instrument.

Screening tools may include as appropriate:

- Parents' Evaluation of Developmental Status (PEDS)
- Pediatric Symptom Checklist (PSC)
- M-CHAT-R/F Screening Tool at 18-24 months (screens for autism)

d. Behavioral and Psychosocial screenings may be done through direct elicitation of parental concerns. The following screening instruments may help clarify referral, counseling, and evaluation options for families with identified concerns:

- Pediatric Symptom Checklist (ages 4-16 years)
- A Psychosocial Interview for Adolescents (H.E.A.D.S.S)

e. Up to four risk screens for maternal depression will be given to mothers during the infant's first year of postpartum. The maternal depression screen will be given at the AAP recommended 1, 2, 4, and 6-month visit if client is on schedule. The patient health questionnaire-9 (PHQ-9) will be the instrument used and any value of 5 or greater (positive screen) will cause the Child Health ERRN to refer the mother to her OBGYN, primary care provider or **Vaya Health** as appropriate. All documentation will be placed into the infant's EHR. When the mother is also the client, she will be given the PHQ-9 during her child health physical and referral to OBGYN/PCP/**Vaya Health** made if screening is positive. An immediate consult will be made to the OBGYN/PCP/**Vaya Health** for a score of 10 or more OR a score of 1 or more on question #9.

f. Dental screening must be performed at every screening assessment. Additionally, referral to a dentist is required for every child by the age of 3 years. Dental referrals should, at minimum, conform to dental service periodicity schedule (currently every six months). When any screening indicates a need for dental services at an earlier age (such as baby bottle caries), referrals must be made for needed dental services and documented in the child's medical record.

g. Appropriate anthropometric measurements and documentation as listed below:

- Weight for age
- Length/height for age
- Head circumference for age (through 24 months of age)
- Weight for length/height or Body Mass Index plotted on age/gender-specific growth chart
- Weight for length/height plotted on children under two years of age or those children 24-36 months of age who are measured lying down
- Body Mass Index is used to assess weight for standing height on children two years of age and older.

h. Dyslipidemia Risk Assessment:
(1) Lipid panel may be performed between ages 9-11 years and again between ages 17-20 years.
(2) Assess risk factors at ages 2, 4, 6, and 8 years and annually thereafter.
(3) See Child Health Risk Assessment Policy.

i. Nutrition Assessment:
(1) A nutrition assessment must be completed during every well child exam per Medicaid periodic schedule. This includes a combination of physical, laboratory, health risk assessment, and dietary determinations carried out during the screening process, which will yield information in assessing the nutritional status of children and youth.
(2) If questions about dietary practices suggest risk factors for co-morbidities, dietary inadequacy, obesity, disordered eating practices (pica, eating disorders, or excessive supplementation) or other nutritional problems, further assessment or an appropriate management plan with referral and follow-up is indicated.
(3) If BMI is **≥ 85%** and risk assessment indicates, follow RCDPH standing order for lab screening for dyslipidemia. See standing order for lab checks completed at health check visit.

j. Age-appropriate laboratory services including:
- Hemoglobin screening
  * Hemoglobin must be measured once at 12 months of age for all children. If the child is 12 months of age or older and there is no hemoglobin value documented, perform a baseline. Selectively screen

with a hemoglobin at other ages based on positive risk factors. Must assess risk factors at 4 months and every Well Child Check visit after the 12-month screen.

* *Repeat test not required if normal result documented within three months of visit.* *

k. As on the Bright Futures forms, one to two priority topics should be discussed as based on parental concerns for the visit. Handouts may be given per Bright Futures on multiple topics.

l. Sexually active adolescents are at high risk for sexually transmitted infections because they have a higher rate of partner change (on average), are more likely to engage in unprotected intercourse, may select partners at higher risk and are biologically more susceptible to infection. For this reason, a risk assessment should be done at each periodic well child exam for youths age 11-18 with screening and/or referral for STI screening in sexually active children. See STI Branch Manual for guidance on identifying risk factors for STI screening recommendations and treatment protocols. (Bright Futures and CDC Guidelines).

m. Tuberculin testing as clinically indicated for children at increased risk of exposure of tuberculosis, via PPD intradermal injection/Mantoux method. See TB Control Manual for guidance on identifying risk factors for exposure to tuberculosis. Screen should be followed-up based on clinical findings.

n. Lead Testing

- Children receiving well child services at the local public health agency will be screened according to targeted screening protocols from the Children's Environmental Health Branch: at 12 and 24 months of age; or upon first well child visit between 36 and 72 months of age, if not previously tested. Blood lead levels ($\geq$ 3.5 ug/dl) will receive confirmatory testing and interventions, per protocols from the North Carolina Childhood Lead Testing and Follow-Up Manual found at https://ehs.dph.ncdhhs.gov/hhccehb/cehu/lead/nclead.htm.

Providers should otherwise repeat lead screening when it is clinically indicated.

- The purpose of this North Carolina Childhood Lead Program is to identify children with elevated blood levels (EBL) and to provide education, anticipatory guidance, and assistant in scheduling follow-up appointments and appropriate referrals to Care Management for At Risk Children (CMARC) and other agencies.
- RCDHHS will provide case management to persons in Rockingham County with elevated blood lead levels.
- The trained lead PHN will work with the lead follow up team (Environmental Health Specialists and the trained lead PHN) and the North Carolina Lead Surveillance System.
- Lead follow up by the case manager will be as indicated by the lead level and according to protocols in the NC Childhood Lead Testing and Follow-Up Manual.

Eligibility

Any child:
- < 6 years of age who resides in Rockingham County receiving services at the RCDPH
- who is referred to RCDPH by the private sector
- referred by the North Carolina Lead Surveillance System
- refugee children < 16 years of age who reside in Rockingham County.

o. Newborn Metabolic/Sickle Cell: North Carolina hospitals are required to perform sickle cell screening for all newborns prior to discharge (as part of mandated newborn screening for genetic and metabolic conditions). If the test results of the newborn sickle cell screening are not readily available, check the State Laboratory for Public Health website (slph.ncpublichealth.com) for sickle cell results. All children without evidence of a previous test will be tested for sickle cell and results documented in the electronic health record (EHR). The nurse screener will try to obtain newborn metabolic screening results for infants up to 6 months of age by contacting the birth hospital. There is no need to repeat the test if results are documented in the child's medical record.

p. Sickle Cell

- The purpose of the North Carolina Sickle Cell Program is to reduce morbidity and mortality in sickle cell diseased individuals and to provide a comprehensive health model for sickle cell disease services. Division of Public Health acts as liaison between the Sickle Cell Disease Association of Piedmont and residents of Rockingham County to fulfill the goals of the Sickle Cell Program and provide counseling/education for persons with abnormal hemoglobins. Education source for sickle cell clinical protocols may be found at https://ncsicklecellprogram.dph.ncdhhs.gov.
- Testing is free upon request.
- Division of Public Health Services will provide case management to persons in Rockingham County with sickle cell disease and other abnormal Hgb types.
- PHN will work with the Sickle Cell Disease Association of Piedmont as necessary to facilitate and maintain adequate delivery of services to the sickle cell clients and those with abnormal Hgb types.

Financial Eligibility:

- There is no cost for screening, education and counseling.
- The Child Health Sickle Cell Case Manager PHN II (SCDCM) receives a printout each month of abnormal hemoglobin electrophoresis results for all children in Rockingham County.
- Lab reports of hemoglobin electrophoreses done in clinics are reviewed by Child Health Sickle Cell Case Manager PHN II.

Abnormal Hemoglobin Electrophoreses:

- If client of Division of Public Health Services – Advanced Practice Provider (AAP) will be notified of results.
- Parent will be notified of results via letter and/or telephone.
- PHN will provide education on Hgb type.
- PHN will offer referral for genetic counsel to be done by Sickle Cell Disease Association of Piedmont (SCDAP).
- Sickle Cell Disease Association of Piedmont will be

notified by letter and copy of results will be sent to them. SCDAP will then be responsible for any further follow-up.
- All case management will be documented and put in child's EHR.
- PHN will assist SCDAP and family with scheduling appointment for genetic counseling. Counseling can be done at the Division of Public Health Services and space will be provided.

Abnormal Hgb Types – The Division of Public Health Services Not Primary Provider:

- Follow all steps for follow-up of abnormal electrophoreses.
- In addition, a letter will be sent to primary MD making him aware of child's results and informing him that all further follow-ups are his/her responsibility.
- All case management will be documented in child's available chart or forwarded to Sickle Cell Disease Association of Piedmont (SCDAP).

Division of Public Health Services Clients:

- PHN will contact parent/legal representative by letter and/or telephone and request that they bring child to clinic for repeat testing.

Unsatisfactory Hgb – Division of Public Health Services Not Primary Provider:

- Primary MD will be notified by letter of need to repeat test and follow-up as results indicate.
- PHN will also notify parent/legal representative via letter to contact primary MD in reference to test results.

Attempts to Contact:

- Two attempts will be made to discuss with parent/ guardian/caregiver results of sickle cell test.
- Attempts will consist of two letters. PHN may also attempt to contact via telephone. Information on sickle cell disease and SCDAP will be sent with second letter.
- PHN will send letter to SCDAP notifying them of unsuccessful attempts to contact family. A copy of child's results will also be sent.

Further Testing (Family Study):

- If a child exhibits Sickle Cell Trait or an abnormal hemoglobanopathy test, the results are sent to the Division of Public Health Services' lab and then forwarded to the SCDCM. The parents also receive a letter from the State laboratory instructing them to report to their local health department for follow-up parent studies. This test consists of the lab drawing an EDTA tube of blood and submitting it to the State lab for testing.
- Once the results of the parent studies are received by the SCDCM, she is responsible for contacting the parents, counseling them regarding the results, and arranges for follow-up counseling with the Sickle Cell Disease Association of the Piedmont.

Termination of Case Management:

- Primary MD is notified of client's results and is aware follow-up is his responsibility.
- Referral has been made to SCDAP – they are aware of results and that further follow-up is their responsibility.
- No response from parent/legal representative after two (2) attempts to contact, SCDAP has been made aware of child's test results and unsuccessful attempts to contact parent.

7. Children seen in Well Child Clinics will have a documented plan of care for identified problems or concerns (nurse or parental) identified in the history or physical assessment. This plan is documented in the Bright Futures format**.**

8. Children with suspected/identified problems or concerns will be referred to or receive consultation from an appropriate source.

9. Infants less than 12 months of age who are served in Child Health Clinics and who have been born to Hepatitis B surface antigen positive mothers will have the following plan and procedures in place:

   a. Care of infants whose mothers are HBsAg Positive or have an unknown HBsAg Status

      HBIG (0.5 ml intramuscularly) should be given as soon as possible after birth, preferably within 12 hours.

Hepatitis B vaccination should be initiated at birth, preferably within 12 hours (MMWR Dec.23, 2005/54(RR 16); 1-23). The dose depends on type of vaccine used.

The first dose of hepatitis B vaccine may be given at the same time as HBIG if it is given with a separate syringe and at a different site. The second and third doses are given 1 month and 6 months after the first.

In 1% to 2% of cases, the recommended immunoprophylactic regimen of HBIG and hepatitis B vaccination is not effective; therefore, infants should be tested at 9-12 months of age and at least 1-2 months after the third vaccine dose for immunoprophylaxis. HBsAg-negative infants with anti-HBs <10 mIU/mL should be re-vaccinated with a single dose of hepatitis B vaccine and receive post vaccination serologic testing 1-2 months later. Infants whose anti-HBs remains <10 mIU/mL following single dose re-vaccination should receive two additional doses of hepatitis B vaccine, followed by PVST 1-2 months after final dose. Based on clinical circumstances or family preference, HBsAg-negative infants with anti-HBs <10 mIU/mL may instead be re-vaccinated with a second, complete 3-dose series, followed by post vaccination serologic testing (PVST) performed 1-2 months after the final dose of vaccine. Those infants who are HBsAg positive should have follow-up testing to determine if they are chronic carriers (defined as HBsAg positive for 6 or more months). Further doses of hepatitis B vaccine in this circumstance are of no benefit.

b. Adopted Infants and Children from High Risk Areas

Adopted infants and children from high-risk populations or those with biological mothers of unknown medical or social backgrounds should be screened for HBsAg.

Initial screening should be performed at 3 months of age or at the time of adoption if it occurs at a later age, and testing should be repeated 6 months later. If the child is HBsAg positive, household members should be vaccinated.

c. Household Contacts of Persons with Acute HBV Infection

Exposed infants (younger than 12 months) – Since the risk of severe or chronic HBV infection is higher in infants, and since little information exists about the risk of an infant acquiring HBV infection from close contact with a household member with acute HBV infection, infants in the

first year of life should both receive HBIG and be vaccinated when acute HBV infection is diagnosed in the infant's mother, father, or principal caretaker.

Exposed children 12 months or older – In a home with a case of acute HBV infection, the index client should be followed serologically to determine if the individual becomes an HBsAg carrier. If the index client becomes an HBsAg carrier, the household contact(s) should be vaccinated.

10. PHN Follow-Up:
Coordinate services for infant/child according to communicable disease Hepatitis B control in infants and children policies and procedures.

11. The Division of Public Health Services will have a plan/procedure in place for follow-up on referrals.

    a. Parental Concerns – PHN will address with education during the visit consult with APP, and/or schedule follow-up appointment with APP, and referral to case management if appropriate.
    b. Identified Risks – PHN will address with consult with APP and possible follow-up appointment with APP, and referral to case management if appropriate.
    c. Identified problems/clinical findings – PHN will address with consult with APP and possible follow-up appointment with APP, and referral to case management if appropriate.
    d. Newborn metabolic screening – PHN will coordinate with laboratory staff and APP and send blood sample if within the time limits.
    e. Coordination with medical home (when the Health Department is not the medical home) – PHN will obtain a signed release from parent/guardian and fax office visit notes, lab results, and screenings to child's medical home.
    f. Missed appointments – PHN will send a letter to parent/ legal representative to re-schedule the missed visit. (Carolina Access children will be referred to CMARC or CCNC for case management for several missed appointments, depending on the age of the child.)
    g. All referrals/follow-up appointments will be made on the day of the visit if possible. If parent/legal representative chooses to make own appointment, it will be documented in the child's record.

F. Rostered Child Health Screeners

1. The agency will maintain records for all rostered Child Health Enhanced Role Nurses showing confirmation of current rostered status. Each nurse will maintain a log of continuing education hours. A report of EPDST screening examinations may be generated at any time from the EHR for each nurse screener upon request.

2. The Division of Public Health Services will report any interruption in service or ability to meet quality assurance deliverables within 14 days to the Regional Child Health Nurse Consultant.

3. The Division of Public Health Services will update changes in contact information for the Child Health Program Coordinator/ Program Supervisor provided to the Regional Child Health Nurse Consultant within two weeks of any change.

4. A copy of the initial certificate of completion of the required training (Child Health Training Program) and a copy of each letter verifying that the individual is rostered or re-rostered for a specific period of time should be maintained by both the individual (in case he/she changes employers) and the employing agency (in the individual's personnel file or a central file related to all rostered screeners.)

5. Applicable towards the continuing education portion of the requirements:

   - Any training approved by the Child Health Branch for continuing education.
   - The Division of Public Health Services will ensure training of all child health staff and implementation of evidence based health literacy strategies in child health clinics and home visits for newborn assessment and care to assure parents and clients can read, understand, and apply health information to make health decisions to improve health outcomes using the Teach Back method of assessing literacy that will include: the client/parent/legal representative explaining back to Nurse/Provider what instructions were provided for them, what they need to know and what they will be doing when they return home.

6. The Division of Public Health Services has policies in place for Child Health Services that include ensuring participation by at least one staff member at Branch supported regional meetings to obtain programmatic updates and service information and dissemination of information to all Child Health Program staff at the Division of Public Health Services.

7. The Division of Public Health Services will assure the following for child health providers:

    a. The Program Coordinator and nursing supervisors are to be provided active electronic mail memberships and direct access to the Internet.
    b. The agency will update changes in contact information for the Program Coordinator/Program Supervisor within two weeks of change. This information will be provided to the State Child Health Nurse Consultant.

G. Child Fatality Prevention Team (CFPT) Objectives:

Local Child Fatality Prevention Teams are one component of the state's three-tiered Child Fatality Prevention System along with the State Child Fatality Prevention Team, and the NC Child Fatality Task Force. Child Fatality Prevention Teams (CFPTs) are responsible for reviewing all deaths of resident children under 18 years of age occurring in the county served that are not reviewed by a separate Community Child Protection Team (CCPT) responsible for review of deaths of children with previous Department of Social Services involvement. In some counties, the CCPT and the CFPT are combined.

1. The Division of Public Health Services will facilitate a Child Fatality Prevention Team (CFPT). Copies of written procedures developed by CFPT Team Coordinator will be distributed to agency administration and members of the CFPT.

2. A staff member of the Division of Public Health Services will serve as chairperson of the team along with the assistance of the health director.

3. The Local CFPTs review medical examiner reports, death certificates, and other records for deceased county residents under age 18. Members discuss outcomes of services and circumstances surrounding the child's death.

4. The primary purpose of the local CFPT is to:

    a. Identify the causes of child deaths;
    b. Identify gaps or deficiencies that may exist in order to improve the delivery of services to children and families;
    c. Make and carry out recommendations for changes that could prevent future child fatalities.

5. The CFPT may consist of appointed representatives of public agencies, non-public agencies, and the community, including:

    - County department of social services

- Local law enforcement agency
- District attorney's office
- Local community action agency
- Local schools
- County board of social services
- Local mental health agency
- Guardians ad litem
- Local health care providers
- Local department of public health
- Emergency medical services
- District court
- County medical examiner
- Local day care
- Parents

The board of health and human services commissioners may appoint a maximum of five additional members to represent county agencies or the community at large to serve on the local CFPT.

6. Team members are responsible for providing information from their agency records about each child's death. The CFPT will rely on members to provide perspective and insight from the vantage point of their agencies and experiences.

7. Each local CFPT member must sign a confidentiality statement. North Carolina law prevents the local CFPT from contacting, questioning, or interviewing families of deceased children as part of the review. The law protects information shared at local CFPT reviews, even from introduction into court proceedings, to maintain each family's privacy.

8. The local CFPT reports to county commissioners their suggestions to prevent future child deaths. Similar reports may also be given to the board of health or introduced at a public meeting. Local CFPTs may not share any single family or child's information in this report. Local CFPTs submit review findings and data to the statewide Team Coordinator. These reports do not include names or other family or child identifying information. The State Team and local CFPTs use this information to form policies and laws, increase public and professional knowledge, and prevent future child deaths.

9. <u>The Goals of the Local Child Fatality Prevention Team:</u>

   a. Involve Diverse Agencies and Disciplines
   Orient, inform, and involve professionals who serve children

b. Collect Data
Collect uniform, retrievable data for all child deaths.

c. Share results
Link child death patterns and trends with agencies and groups that can create and support strategies to prevent child deaths – identify system problems and make recommendations.

d. Act to Prevent Child Deaths
Launch state and local action to prevent child deaths.

e. Reduce the Number and Rate of Child Deaths

10. The local Child Fatality Prevention Team will follow the policies & procedures set forth through the Rockingham County Child Fatality Prevention Team Manual.

11. Records, including minutes of all official meetings, a roster of CFPT members, letters of appointment, operating procedures, and signed confidentiality statements for all members and invited guests will be maintained.

12. Findings in connection with child death reviews will be reported to the Team Coordinator by submitting a Confidential Child Fatality Prevention Team Report within 45 days after the completion of each case review. Note: Child death reviews may require several meetings before completion.

13. A CFPT Annual Report will be completed and submitted to the Team Coordinator by the requested due date.

14. Reports will be made quarterly to the local board of health, or as required by the board on the activities of the CFPT. The quarterly reviews are conducted to:

- Identify system problems that contribute to preventable child deaths;
- Develop local action plans to reduce preventable deaths; and
- Develop recommendations for legislative and/or administrative changes to the State Team and Child Fatality Task Force.

15. All child fatalities not reviewed by the Community Child Protection Team will be reviewed by the CFPT.

16. Documentation of subcontracts with agency(ies) to provide support staff for the CFPT will be submitted to the Team Coordinator.

H. Quality Assurance Deliverables

1. The local health director will assure that the local (county) Child Fatality Prevention Team completes mandated services (GS 7B.1407) including:

    a. Completion of reviews according to legislative guidelines and WCHS policies and procedures.
    b. Submissions of required reports to state CFPT Coordinator.
    c. Reports of local team activities and findings to the local governing board, quarterly or as requested.

2. The Team Chair is responsible for:

    a. Oversight of local team operation;
    b. Scheduling and facilitating quarterly team meetings;
    c. Receiving, compiling and disseminating information necessary to conduct reviews;
    d. Reviews should be initiated within three months and completed within nine months of receipt of information packet from the state CFPT Coordinator. (Packets are sent to the Team Leader in mid-December, March, June and September for review in the following quarter. In general, materials included in each packet are for deaths that occurred during the same quarter of the previous year.)
    e. Submitting confidential death review reports to state CFPT Coordinator within 45 days after the review is completed.
    f. Preparing report of local team activities to be submitted annually with agreement addenda. (This information will be incorporated into Child Fatality Task Force annual report.)
    g. Maintaining the following information for the local CFPT:

        (1) Minutes of all official meetings
        (2) Member roster
        (3) Letters of appointment
        (4) Operating procedures, and
        (5) Signed confidentiality statements for all members and invited guests.

I. School Health

1. The Division of Public Health Services maintains a written agreement with the Rockingham County School System.

    This agreement reflects joint planning in:

    - program goals and objectives
    - roles and responsibilities defined for each agency including a formal plan for emergency and disaster use of school nurses

- a description of process for developing written policies and procedures
- provision for annual revision of the agreement.

2. The Rockingham County public health nurses will provide services to the Rockingham County Schools according to standards set by the North Carolina Department of Health and Human Services and the North Carolina Department of Public Instruction.

3. The School Health Program will be administered according to guidelines in the School Health Manual and the Division of Public Health Services' Protocols signed by the Division of Public Health Services' consulting physicians.

4. Public Health Nurses are available to school health nurses for consultation, coordination, and follow-up of health services, for children enrolled in Rockingham County Schools.

5. The Division of Public Health Services will:

   a. Ensure/Assist with health assessment by:

      - Reviewing, upon request, records of any child whose health assessment gives rise to question by principal, teacher, or school nurse.
      - Assisting parents in arranging health assessment when necessary.
      - Assisting parents in carrying out any referrals made on the basis of the health assessment.
      - Providing basic health assessment, upon request by parent, to those preschool children whose parents indicate no other health resource and whose income meets financial guidelines of the Division of Public Health Services for that service.
      - Providing routine health screening to other school-age children who meet the financial criteria of the Child Health Program.
      - Re-Screening

        Any child referred by teacher/principal or other school personnel for any suspected health problem (lice, scabies, impetigo). Written referrals will be sent to parent, and follow-up made as needed by public health nurse consistent with time available.

   b. Advise/Assist with consultation of school administration, principals, teachers, and students in the area of child health.

- The public health nurse, Environmental Health Section, or nutritionist may provide consultation and assist with health concerns such as communicable disease, accident prevention, environmental hazards, nutrition services, and handling of special problems.
- The public health nurse, Environmental Health Section, or nutritionist may serve as a resource person in the areas of health service, health education, environmental health, and nutrition.
- The public health nurse, Environmental Health Section, and nutritionist may, within limits of their availability, provide health counseling and educational sessions to groups.

c. Assist with school immunization compliance according to NCGS 130A-1 SS.

- Assist in review of incomplete or questionable immunization records.
- Review immunization records of children entering school for the first time or whose record gives rise to question by principal, teacher, or, school nurse.
- Advise school nurse of students not in compliance.
- Assist parents in getting immunization records.
- Keep school office informed of special problems.
- Division of Public Health Services will provide on-site immunizations during regularly scheduled clinics as the need arises to mitigate barriers and increase immunization compliance.

d. Health Assessments to children enrolling in public/charter schools are pursuant with House Bill 13, Session Law 2015-222.

e. A copy of the current fiscal year agreement will be signed by both agencies and submitted to the Regional School Nurse Consultant.

J. Physical Examination Forms for Children Attending Daycare, School, or Camp

The Division of Public Health Services enhanced role Child Health Nurses or APPs will not complete daycare, school or camp physical examination forms for children who have not had a regular well child visit in more than twelve months. Any parents requesting that this be done should schedule a physical examination in the Child Health Clinic at their earliest convenience.

K. Carolina Access

The Division of Public Health Services will provide after hour coverage for clients that receive Carolina Access. An APP or a member of the nursing staff is available via telephone, after hours, weeknights, holidays, and on weekends. Refer to policy, Carolina Access Primary Care and After Hours Weekend Coverage policy.

L. Other Related Services

1. Genetic Health Care Services

Clients from all clinics requiring Genetic Health Care services will be referred to the State Genetic Counselor. Genetic services are available at five medical centers and one community hospital in NC for any infant, child, or adult suspected of having a genetic condition. This also includes services for pregnant women that are at an increased risk to have a baby with birth defects.

Services available in our region include:

- Genetic Counseling
- Genetic Evaluations
- Prenatal Counseling and Diagnosis
- Genetic Education

For information and services contact the State Genetic Counselor at 919-707-5600.

May also contact Genetic Counseling
Wake Forest University Medical Center
Winston Salem
Clinical Services 336-713-7573
Fax 336-713-7577

2. Child Development Services Agencies

The North Carolina Early Intervention Branch is a part of the N.C. Division of Public Health. It is the lead agency for the N.C. Infant-Toddler Program (ITP). The ITP provides support and services for families and their children, birth to three who have special needs. Sixteen Children's Developmental Services Agencies (CDSAs) across North Carolina work with local service providers to help families help their children succeed.

To refer a child 0-3 years with a developmental delay or special needs, the Child Health Nurse will refer the client to CMARC. CMARC will offer their services to the family and place a referral to the local CDSA office in Greensboro, if needed.

Financial Eligibility: Sliding Fee Scale, Medicaid, and other third party payment sources. No family is denied service because of the inability to pay.

3. Physician Back-up Services

In the absence of the APP in Primary Care Clinic, the supervising consultant physician will be notified for services as needed if clients present with symptoms that extend beyond the scope of practice of the RN.

4. Program Assurance

a. Annually review child health outcomes and related trends for the County and State to identify major opportunities to improve these outcomes and reduce disparities in the County especially disparities related to race, ethnicity, disability, and socioeconomic status. This information should be used in developing strategies that will promote customer friendly services that meet the needs of the populations that are underserved. Staff education on disparities will be accomplished through annual staff training, workshops, and annually with the review of policies. Resources can be found at https://www.ncdhhs.gov/assistance/disability-services. The following state and county level data sources are available on the **NC State Center for Health Statistics** website **https://schs.dph.ncdhhs.gov/data**.

(1) Child Health Assessment and Monitoring Program (CHAMP)
(2) **County Health Data Book**
(3) **Behavioral Risk Factor Surveillance System (BRFSS)**
(4) **North Carolina Statewide and County Trends in Key Health Indicators**

b. Ensure child health services provided by nurses meet North Carolina Board of Nursing scope of practice guidelines, including nursing standing orders. http://www.ncbon.com/

c. Ensure child health services provided by nurses meet all the age specific requirements in the most recent Health Check Program Guide (HCPG).

M. Improving Organizational Performance

1. Annually, the Division of Public Health Services will review child health outcomes and related trends for county and the state to

identify major opportunities to improve these outcomes and reduce disparities in the county.

2. The Child Health Program and charts will be audited quarterly.

   a. A minimum of 2 client records per screener per quarter will be reviewed. These reviews will include samples of the child health nurse charts. All disciplines will participate in the audit.
   b. The purpose of the chart audit will be to:

      - Ensure that the level of medical care specified by the contract addendum, HCPG, Child Health Policies, procedures and protocols of the specified programs are being met.
      - Discuss problems in clinic and Child Health Program and make recommendations to correct deficiencies found, and other improvements.
      - Ensure all coding is accurate and billing is appropriate for age per the most recent HCPG.

   c. The chart selection will be based randomly selected records from the quarter in review. The state audit forms will be used. The results of the audit will be tabulated and recorded. Information discussed within the report may have the client medical record number rather than any other identifying information.
   d. All members of the program team will be informed of the results of the audit. The strengths and weaknesses will be identified and summarized along with a corrective plan of action.
   e. Results of the audits are provided to the Child Health Nurses/Providers and areas of concern are discussed to plan improvement activities.
   f. The Nursing Supervisor who is responsible for the coordination of the Child Health Program will sit on the Quality Improvement Council to serve as the Child Health content expert.
   g. A program overview of the projected percentages and the contract addendum requirements are completed at the end of the first six months into the fiscal year with focus on projections for the first six months and how they are met. At the end of the fiscal year programs will be reviewed to identify any unmet needs and guidelines will be established for the upcoming fiscal year.

3. The Division of Public Health Services Program Staff will maintain client confidentiality following the Division of Public

Health Services HIPAA Policies. The registered nurse will determine what information can be released and what sensitive information must be redacted without another individual's release.

N. The Child Health program will distribute client satisfaction surveys.

1. Client Satisfaction Surveys are distributed monthly via a text message link, attempting to capture all clients that present for Child Health services.

2. The results will be compiled and a report of the findings will be distributed among staff. Areas for improvement will be addressed. A copy **of the results will** be sent to the Child Health Regional Nurse Consultant for review **twice per year**.

3. The Division of Public Health Services Board of Health and Human Services will be receiving a quarterly summary of the client satisfaction survey results.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
PROCEDURE

TITLE: OTOREAD OTOACOUSTIC EMISSION (OAE) SCREENING BIRTH TO TWENTY-ONE YEARS OF AGE

DATE DEVELOPED: **3/05**
REVIEWED: **6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/15; 6/19; 6/21; 6/22; 6/23**

I. POLICY:

The Division of Public Health Services will provide OAE screenings to children in the clinical setting to assess for hearing loss.

II. PURPOSE:

To provide a rapid measurement and documentation of distortion product Otoacoustic Emission or transient evoked Otoacoustic emissions at several frequencies.

III. GUIDELINES:

A. The OtoRead (O.A.E.) system should be used only by those individuals trained to perform the testing for which it has been designed.

B. Risk assessment will begin at two months of age if newborn hearing exam is passed after birth at hospital. OAE screenings will be performed when a parent or staff member has a concern about a child's hearing. Newborn rescreens can be performed at the Division of Public Health Services. Infants should be referred for diagnostic audiological evaluation following a "refer" result on two hearing screenings (i.e. initial newborn hearing screening and one follow-up re-screening), which should occur before the age of 1 month. The diagnostic audiological evaluation should be completed by the age of 3 months by a pediatric audiologist. Diagnostic testing sites can be found at https://ncnewbornhearing.dph.ncdhhs.gov. The Regional State Audiologist will be notified of OAE results for children under six months of age. It is recommended that pure tone audiometer screening be done on children over four years of age and adults. If a child is unable to be tested with the pure tone audiometer, the OtoRead OAE may be used for screening and the screener will document in the client's record the reason for not using the audiometer. The schedule for objective hearing screenings will follow the latest guidelines from the NC Medicaid Health Check Program Guide.

C. Initial Screening:

1. Visual inspection of outer ear looking for malformations, ear tags, pits, etc. and refers for medical follow-up when warranted.

2. Visual inspection of ear canal and middle ear (with otoscope) looking for excessive cerumen, debris, drainage, redness, etc. and refer problems for medical follow-up.

3. Assess children for tubes in ears using special procedure for those children (turn OtoRead on and hold R or L arrow key for 3 seconds until green test light goes off. Once the key is released the OtoRead will calibrate and test as before).

4. Ensure 4 AA/um – 3/R6 alkaline batteries are in the OtoRead.

5. Place an ear tip as far down as possible on the probe tip (the disposable ear tips are color coded to facilitate easy selection by size). The smallest ear tips are used for infants and children and the larger ear tips for adults.

6. Turn on the OtoRead by pressing the large down arrow button.

7. Select the test ear by pressing the L or R arrow key.

8. Insert ear tip deeply into client's ear canal to obtain a seal. When seal is obtained the OtoRead will automatically begin the test first calibrating and then testing emission. The screen will illuminate "NOISE" if there is noise in the environment. Once testing is finished, the unit will display "Pass" or "Refer" on the LCD display.

9. When OtoReader LCD reading is pass or refer record results in the electronic health record.

10. When OAE LCD reading is refer, rescreen child in 2-4 weeks after initial screening or medical clearance using same protocol as initial visit. If OtoReader LCD indicates refer on 2nd listing, refer child for medical follow-up.

D. Equipment Care:

1. Do not conduct screening unless ears are clear of wax/drainage.

2. Do not expose OtoReader OAE to extreme temperatures.

3. Keep extra batteries on hand and do not mix old and new batteries in OtoReader.

4. Keep probe tip clear of debris.

5. See manual for troubleshooting.

6. Perform testing in a quiet environment for proper testing and accuracy. Loud noise can interfere with the OAE test.

E. Billing Guidelines:

1. 92558 code will be used for Otoacoustic emissions (OAE) screening.

2. Rescreens can be billed. Bill only after verifying the procedure is within the appropriate billing guidelines.

F. Precautions:

1. The OtoRead instrument probe tip must not be inserted into an ear at anytime without a disposable ear tip. Use only disposable ear tips designed for the OtoRead instrument.

2. Do not immerse unit in any fluids. Clean surface with a cloth slightly dampened with mild detergent or normal hospital bactericides. Do not clean with isopropyl alcohol or other solvents.

3. Do not use machine if damage suspected.

4. Use or store instrument indoors only.

5. Do not use instrument or accessories in temperatures below 40^0F or above 100^0 F, or in relative humidity of more than 90%.

6. Return instrument to the manufacturer for all service.

7. It is recommended all staff read operation manual prior to use and periodically review.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
PROCEDURE

TITLE: USE OF PEDS-R/PSC SCREENING METHOD IN THE EVALUATION OF DEVELOPMENTAL STATUS IN CHILDREN

DATE DEVELOPED: 12/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/18; 6/20; 6/22; 6/24

I. POLICY:

The Division of Public Health Services Program shall screen and evaluate the developmental status of children who receive physical assessments through this program.

II. PURPOSE:

The purpose of this policy is to enhance the identification, referral and treatment of children identified with potential developmental delays as early as possible utilizing a reliable user-friendly tool. Early identification of developmental delays with the augmentation of early intervention services improves the future educational outcome for the client.

III. GUIDELINES:

A. Parents' Evaluation of Developmental Status-**Revised (PEDS-R)** is a screening method for detecting and addressing developmental and behavioral problems in children 0-8 years of age. The Division of Public Health Services uses **PEDS-R** on children 0-5 years of age.

1. Consists of a questionnaire with **twelve** questions relating to:

   a. **First Impressions**;
   b. Expressive Language and Articulation;
   c. Receptive Language;
   d. Fine Motor;
   e. Gross Motor;
   f. Behavior;
   g. Social-Emotional;
   h. Self-Help;
   i. School;
   j. **Global/Cognitive;**
   k. **Health;**
   l. Other Concerns.

2. The age of the child determines how the evaluation is interpreted. A score determines which interpretation path the scorer should recommend to the parent/verified personal representative. **The scorer should use the PEDS-R Score Form and the PEDS-R Interpretation Form to determine path, risk, and appropriate action steps.**

3. The **PEDS-R** screening tool is available in both English and Spanish versions and an interpreter can be used when assistance is needed by the parent/verified legal representative.

4. The **PEDS-R** screening tool must be used at Routine Healthcare Supervision (Well Child) visits at ages 6 months, 12 months, 18 or 24 months, and 3 years, 4 years, and 5 years.

5. Children for whom the **PEDS-R** screening tool recommends follow-up will be **offered a referral** to the CMARC program, **CCNC**, or a mental health specialist **based on recommended path**.

B. The Pediatric Symptom Checklist (PSC) can be used from the age of 4 years to 16 years of age. The Rockingham County Department of Public Health Child Health Program uses this developmental evaluation screening tool for children ages 6 years and older.

1. The PSC screening tool consists of 35 questions with response check boxes of: Never, Sometimes, and Often.

   a. A score of "0" is assigned to all Never responses;
   b. A score of "1" is assigned to all Sometimes responses;
   c. A score of "2" is assigned to all Often responses.

2. Five of the 35 questions (4, 7, 8, 9, and 14) relate to potential attention (ADHD) problems when a score of 7 or more points is obtained. The Child Health Nurse recommends a referral for evaluation by an educational or mental health specialist if the score in these five questions indicates a potential problem.

3. Five of the 35 questions (11, 13, 19, 22, and 27) relate to potential internalizing issues such as depression and anxiety when a score of 5 or more points is obtained. The Child Health Nurse recommends a referral for evaluation by a mental health specialist if the score in these five questions indicates a potential problem.

4. Seven of the 35 questions (16, 29, 31, 32, 33, 34, and 35) relate to potential conduct disorders if a score of 7 or more points is obtained. The Child Health Nurse recommends a referral for an evaluation by

a mental health specialist if the score in these seven questions indicates a potential problem.

5. For children under the age of 5 years, responses in 4 questions (5, 6, 17, and 18) are not counted in the total score due to their emphasis on school issues that may not be relevant.

6. The presence of significant behavioral or emotional difficulties is suggested when children ages 4-5 years receive 24 or more points, and when children ages 6-16 years receive 28 or more points.

7. Children who fail the whole test shall be referred to educational and/or mental health specialists for further assessment.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
PROCEDURE

TITLE: DENTAL VARNISHING

DATE DEVELOPED: 5/01
REVIEWED: 6/16; 1/17; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/17; 6/17; 6/19; 6/22; 6/23; 6/24

I. POLICY:

The Division of Public Health Services will provide dental varnishing to eligible children beginning with the first eruption of teeth to age 42 months.

II. PURPOSE:

A. To identify at risk children who are in need of dental varnishing services.

B. To reduce tooth decay and dental disease by providing preventive procedures early in childhood.

III. GUIDELINES:

A. Eligibility Criteria –

All clients under the age of 42 months regardless of insurance status.

B. Conditions for Treatment -

1. May begin first treatment with the first eruption of teeth, which may be between the ages of 6-9 months.

2. May provide up to six treatments until the child reaches the age of 42 months. Treatment may not be provided after the child is 3 ½ years old.

3. Treatments must be separated by a 60-day period between applications and may be performed every 3-4 months.

4. Treatment may have been initiated at another provider/facility. However, treatment can still be provided by Division of Public Health Services and the series of treatments can be continued until the client reaches the age of 42 months. The provider/facility initiating treatment may have to be contacted by Division of Public Health Services in order to establish the time frame of when the last treatment was provided.

5. Treatments may be offered during the following clinical visits:

Clinic

(1) Well child check-up

(2) Follow-up dental varnishing visit alone
(3) Sick visits

Ideal workable schedule to provide treatment:

6 months - during well child visit, sick visit, Health Check screening
9 months - during well child visit, sick visit, Health Check screening
12 months - during well child visit, sick visit, Health Check screening
18 months - during well child visit, sick visit, Health Check screening
24 months - during well child visit, sick visit, Health Check screening
Between age 24 or 42 months

Time frame may vary depending on the follow-up schedule visits made. The intent is to identify the need and provide treatment incorporated with the child's visits.

C. Providers – May be the following:

1. Rostered Child Health Nurses
2. Registered Nurses
3. Licensed Practical Nurse
4. Advanced Practice Providers (APPs)

All providers of dental varnishing must be properly trained. Providers must complete a training session with the Regional Public Health Dental Hygienist.

D. Procedure –

1. Supplies Needed:

a. Fluoride Varnish (**Nupro**)
b. Small disposable brush
c. Disposable dental mouth mirror (to enhance visibility)
d. Tongue blades
e. Latex/vinyl gloves
f. Flashlight (to direct light source)
g. Drape/Covering
h. Disposable bite block

2. Overview/Introduction - Review and instruct parent/guardian on Fluoride Varnish treatment and procedure.

3. Position the Child

a. For an infant -

- Place child on the parent's lap with head on parent's knees and legs around waist and position yourself knee-

to-knee with the parent and treat the child from above the head
- Place the infant on an exam table and work from above the head, or
- As you gain experience, do whatever works best for you.

b. For a young child -
- Place the child in a supine or sitting position and work from above the head, or
- Adapt a method that works best for you.

4. Application

a. Peel off foil lid. Choose a holding position that is most comfortable for you.
b. Mix thoroughly with applicator brush. Paint a thin layer of fluoride varnish directly on to teeth using applicator brush provided.
c. Allow treated area to become wet either by gentle rinsing or by natural salivary flow.
d. Dispose of the patient dose cup after treatment.

5. Screening – During the exam, screen for the following:

a. Early caries (decay) – chalky, white area on the teeth enamel. There may be extensive decay with cavitation and staining of the enamel. Continue to provide fluoride varnish treatment. This will slow the decaying process and will also prevent the development of new lesions.
b. Stains, plaque, fluorosis and enamel hypoplasia, and hypomineralizations may also be observed and, under the conditions, may be difficult to distinguish from caries.
c. Observe for trauma that may appear as chipped or misplaced teeth.
d. Observe for inflammation, ulceration, trauma or lumps and bumps of the soft tissue.
e. Refer the child to the dentist if any abnormalities are noticed.

6. Post-application Instructions - Instruct the parent

a. Do not brush or floss treated area for at least 2 hours after treatment.
b. Avoid hard, hot or sticky foods, hot beverages, and products containing alcohol (including oral rinses) for 2 hours.
c. Avoid using other products containing fluoride (mouthwashes, gels, prescription toothpaste) until the next day.

E. Documentation

1. The following forms must be completed during the exam and treatment:

   - Dental Varnish section in the electronic health record or if unavailable use Oral Health Screening and Fluoride Varnish Program Form – Intra Oral Charting Form – Check all that apply. (Retain copy in the client's medical record.)

2. Additional Instructions –

   a. Instruct parent on limiting child's sugar intake.
   b. Eliminate bottle use by age one.
   c. Do not put child to bed with a bottle with formula or juice (may with water).
   d. Encourage regular brushing and flossing of the teeth by parent using a small amount of fluoridated toothpaste. Encourage the importance of regular dental exams and preventive care. Encourage parents to begin regular dental visits at 12 months of age.
   e. For children 3 years and older, if no dental home is established, the child must be referred to a dentist for dental care.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CHILD HEALTH RISK ASSESSMENT

DATE DEVELOPED: 5/5/10; 6/12
REVIEWED: 1/17; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 1/23; 6/23; 6/24
REVISED: 1/17; 6/17; 6/18; 6/19; 6/22; 1/23; 6/24

I. POLICY:

The Division of Public Health Services strives to provide a continuous process of accessing health and function of children including disease detection and prevention, health promotion and anticipatory guidance. The agency will perform routine age-specific screening during Well Child Checks (WCC) as required by the 351 Agreement Addenda (AA) and Health Check Program Guide (HCPG). At all other WCC, when age-specific hearing, pregnancy, sexually transmitted infection, tuberculosis (TB), and vision will be completed per Child Health Program or Medicaid requirement. Documentation will be included within the Bright Futures documentation.

II. PURPOSE:

To assess the parent/legal representative and child's risks and concerns, to obtain and update child/family history, review of systems and provide continuous evaluation of socioeconomic, behavioral, social and academic competencies and risks.

III. GUIDELINES:

A. Anemia Risk Assessment

1. Infants

a. Risk assessment to be performed at 4 months of age.
b. Measure hemoglobin once for all infants at age 12 months.
c. At all other visits after 12 months**,** assess risk and if risk factor(s) present, measure hemoglobin. Infant specific risk factors include:

- Prematurity
- Low birth weight
- Low iron formula
- Early introduction of cow's milk

d. Obtain hemoglobin at any visit after 12 months of age if there is no hemoglobin result documented in the EHR. This value will serve as a baseline reading for future assessments if needed.

2. Children and Adolescents

a. An assessment of risk for anemia will be performed at all other WCC visits and hemoglobin screening test done as a result of a positive risk assessment. Overall child and adolescent risk factors:

- Limited access to food
- Low iron diet
- Strict vegetarian diet without iron supplement
- Risk of iron deficiency due to special health care needs

b. Specific risk factors for female adolescents 11-21 years old:
- Extensive menstrual or other blood loss
- Low iron intake
- Previous diagnosis of iron deficiency anemia

B. Autism Spectrum Disorder (ASD) Risk Assessment

1. Children 18 and 24 months screen using Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F).

a. Give one point to an answer of "No" to any questions except 2, 5, and 12. Give one point to an answer of "Yes" to questions 2, 5, and 12.
b. Screen is positive for a score of 3 or more.
c. If child is younger than 24 months and scores 0-2, re-screen after second birthday; otherwise, no further action is required.

2. Surveillance at all other WCC visits. Four surveillance risk factors:

a. Sibling with ASD
b. Parent concern, inconsistent hearing, unusual responsiveness
c. Other caregiver concern
d. Pediatrician concern

3. If one risk factor and child is at least 18 months old, use screening tool.

4. When screen is positive, refer to Care Management for At Risk Children (CMARC) for Early Intervention (EI), ASD Evaluation, and Audiology.

5. If two risk factors or more, refer to CMARC for Early Intervention (EI), ASD Evaluation and Audiology simultaneously.

C. Dyslipidemia Risk Assessment

1. Lipid panel may be performed between ages 9-11 years and again between ages 17-20 years.

2. Assess risk factors at ages 2, 4, 6, and 8 years and then annually.

3. Risk assessment to be done at all other WCC visits.

4. Specific risk factors are:
   - Family history of dyslipidemia
   - Family history of premature cardiovascular disease (CVD) (heart disease or stroke)
   - Child with a history of other CVD risk factors (overweight or >85% BMI, daily cigarette smoking, HTN, Type II DM, etc.)
   - Child with no family medical history available

5. If one or more risk factors are positive, have a fasting (or non-fasting) lipid profile drawn to include total serum cholesterol, TG, HDL, and LDL.

6. Normal result – if within reference range retest in 5 years and provide anticipatory guidance.

7. Abnormal result – follow agency standing order (CH-5) for repeat labs, follow-up and referrals.

D. Hearing Risk Assessment

1. Newborn and then annual screening at ages 4-6 year old visits. Again at age 8 years, age 10 years, and <u>once</u> between ages 11-14, ages 15-17, and ages 18-20.

2. Risk assessment to be done at all other WCC visits

3. Risk assessment factors include:

   - Parent or child reports problems with hearing, speech, or language
   - History of systemic or chronic disease
   - History of birth or infant risk factors
   - Exposure to damaging noise levels
   - Head trauma with loss of consciousness
   - Recurring ear infections
   - History of ototoxic medicines

4. If screening not due and risk factors positive screen hearing and follow agency procedure for follow-up and/or referral.

5. If screening not due and risk factors negative reassess risk at next visit.

6. If screening due and abnormal results refer to audiology.

7. If screening due and normal assess need for screening at next visit.

E. Vision Risk Assessment

1. Annual screening from ages 3-6 year old visits. Again at age 8 years, 10 years, 12 years and 15 years.

2. Risk assessment to be done at all other WCC visits.

3. Risk assessment factors include:

- Parent or child reports eye or vision problems
- Birth or infant risk factors
- History of systemic or chronic disease
- Academic problems
- History of eye injury
- Family history of eye or vision disease

4. If screening not due and risk factors positive screen vision and follow agency procedure for follow-up and/or referral.

5. If screening not due and risk factors negative reassess risk at next visit.

6. If screening due and abnormal results refer to optometry or ophthalmology.

7. If screening due and normal assess need for screening at next visit.

8. Vision Screener

- May be used to assess risk at 12 months, 24 months, and 3 year to 5 year visits.
- May be used on older children who are non-verbal or who cannot complete an objective vision screen.

F. Tuberculosis Risk Assessment

1. Risk assessment to be done at every WCC visit.

2. Risk assessment factors include:

- Family member or child had TB contact
- Family member had/has positive TB skin test
- The adult/child HIV positive
- Adult/child uses illicit drugs
- Child/youth is a migrant, seasonal farm worker (homeless, or incarcerated, HIV positive)
- Child/youth was born in a high risk country and been in USA less than 5 years
- Child/youth has traveled to a high risk country and had contact with a resident for more than one month

3. If risk assessment positive follow agency procedure for placing TB skin test, follow-up and referral.

4. If risk assessment negative reassess on next well child check visit.

5. If child presents with clinical symptoms place TB skin test.

   - If positive skin test, follow procedure for follow-up and medication treatment per TB policy.
   - If negative skin test rescreen per TB policy.

G. Pregnancy Risk Assessment

1. For sexually active females a risk assessment is to be done at every WCC visit.

2. Risk assessment factors include:

   - Missed periods
   - Unexplained vaginal bleeding
   - Unprotected sex
   - Abdominal pain
   - Concern expressed by youth of possibly being pregnant

3. If risk assessment is positive consult with the Advanced Practice Provider (APP) for evaluation and/or referral.

4. If risk assessment is negative provide anticipatory guidance, birth control options, or appropriate referral.

H. STI/HIV Risk Assessment

1. High risk adolescents can be screened outside of the WCC as indicated based on risk. If an adolescent has any STI, refer to Family Planning/STI clinic and the clinic will test for syphilis and HIV per family planning/STI guidelines.

2. Risk assessment factors as follows:

- Sexually active and no symptoms
- Male and has sex with males and engages in high risk sexual behavior
- Sex with new partner since last test
- Sex with HIV infected person
- Sex for money or treated for STI, Hepatitis or TB
- Partner with above factors
- Injectable drugs or steroids
- Incarceration
- Increased prevalence in population
- Attending Job Corp
- More than one sex partner since last test

3. Once established that the youth is sexually active, screen for GC, Chlamydia, HIV, and Syphilis. Child may be referred to Family Planning/STI Programs for these services.

   a. Screening for GC/Chlamydia

      - Annually for all females
      - Annually for males who have positive risk factors

   b. Screening HIV

      - **Screen adolescents for HIV at least once between the ages of 15 and 21**
      - Annually for males and females with a positive risk factor
      - **Risk assessment starting at age 11 and voluntarily offer to screen with negative risk factors**

   c. Screening for Syphilis

      - Annually for male and females with positive risk factors

I. Maternal Postpartum Depression Screening

1. Mothers of infants receiving a WCC at the 1, 2, 4, and 6-month visits will receive postpartum depression screening with the patient health questionnaire-9 (PHQ-9).

   a. Mothers who have a positive postpartum depression score (value of 5 or greater) will be referred to her OBGYN, primary care provider (PCP), or Sandhills Center as appropriate.
   b. All documentation will be recorded in the infant's EHR.

2. When the mother is the client being seen for the WCC, she will be given the PHQ-9 and all documentation is recorded into her EHR. Clients with a positive score (5 or greater) will be referred to their OBGYN, PCP, or **Vaya Health** as appropriate.

3. Consult with OBGYN, PCP, or **Vaya Health** immediately for scores of 10 or more OR score of 1 or more on question #9.

4. May refer any mothers or fathers who would like extra support to https://www.postpartum.net. Website offers counseling and peer support groups via telephone, text, and website chat.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DOCUMENTATION BY EXCEPTION FOR CHILD HEALTH EXAMINATION

DATE DEVELOPED: 4/15
REVIEWED: 1/17; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 1/23; 6/23; 6/24
REVISED: 6/16; 1/17; 6/18; 6/22; 1/23; 6/24

I. POLICY:

The Division of Public Health Services provides a basis for accurately documenting a child health examination. Normal findings are not documented.

II. PURPOSE:

To establish normal findings during a well-child exam; this includes normal growth and development. If abnormal findings are identified the provider shall document the abnormal findings and follow-up actions as needed.

III. ASSESSMENT

All material is referenced from Engel, J.K. (2006). *Mosby's Pediatric Assessment* (5th ed.). Mosby.

A. HEAD

1. Minor asymmetry in infant heads younger than 4 months is common and is related to molding. A head might be longer, narrower, or flatter than expected as a result of genetic influences.
2. Head circumference - See chart after measurement plotted for abnormal range.
3. Sutures are felt as prominent ridges or like cracks between the cranial bones. In a newborn infant the suture lines override as a result of molding, but usually flatten out by 6 months of age.
4. The anterior fontanel should be soft, flat and pulsatile. The fontanel bulges slightly when infant is crying.
5. Until ages 9-12 months the anterior fontanel measures from 1-5cm in length and width.

B. NECK

1. The infant younger than 4 months of age might show head lag when pulled into a sitting position.
2. The child should exhibit no pain limitation in movement in any direction.
3. The trachea should be midline or slightly to the right.
4. In normal children the thyroid gland is not felt.

C. EARS/HEARING

1. Top of the ear should cross imaginary line from the inner eye to the occiput. The pinna should not deviate any more than 10 degrees from the perpendicular to the horizontal imaginary line. Ears are normal location, asymmetry and appearance.
2. Ears of a neonate are flat against head.
3. Pulling on ear normally causes no pain.
4. No pain or tenderness should be experienced when palpating the mastoid.
5. The infant younger than 4 months of age evidence the Startle Reflex. Infants 6 months or older will try to locate sound by shifting the eyes or turning their heads. Infants older than 12 months will localize sound beside, below and above.

OTOSCOPE EXAM:

1. Ear canal pink, tympanic membrane translucent and pearly pink or gray.
2. Slight redness is normal in newborns and older crying children.

HEARING EXAMS:

1. OAE Exam will give PASS/FAIL results.
2. TYPANOMETER Exam child should pass 20 decibels at 1000 Hz, 2000 Hz and 4000 Hz. **Children ages 11-20 should also pass 20 decibels at 6,000 Hz and 8,000 Hz.**

D. EYES

1. Evaluate that eyes are positioned correctly in head and proper slant.
2. Note eyebrows are positioned correctly and hair growth even.
3. Note eyelids for color and there should be no swelling or discharge.
4. Conjunctiva clear without redness.
5. Sclera should be white, clear (tiny black marks are normal in dark skinned children).
6. Irises- Irises may be a different color, round, clear.
7. Cornea clear.
8. Pupils same size, equally reactive to light, round, constrict to light. In infants younger than 5 months pupil inequality is common but should be considered significant if any central nervous system findings are also present.
9. Field of vision - Child should be able to follow object through 6 fields of visions with a few beats of nystagmus.

VISUAL ACUITY:

1. Visual acuity in infant fixes objects 8-12 inches from mothers face.
2. 4 Months - 20/300 to 20/50
3. 3 year old - +- 20/40
4. 5 year old 20/30 to 20/20
5. Vision Screener gives PASS/FAIL results with the corresponding statements of "screening complete" or "complete eye exam recommended".

OPTHALMASCOPE EXAM:

1. In Infants the optic disk is pale and the peripheral vessels are not well developed. The red reflex appears lighter.
2. In children the red reflex appears as a brilliant reddish-yellow (or light gray in dark skinned, brown eyed children) with uniform glow. The optic disk is creamy white to pinkish with a clear margin. At the center of the optic disk is a small depression. Arteries are smaller and brighter than veins. The macula is the same size as the optic disk and located to the right of the disk. The fovea is the glistening spot at the center of the macula.

E. INTEGUMENTARY SYTEM

1. Skin is warm, dry, smooth, and even with no odor, abnormal coloring, lesions, and rashes. Turgor is assessed and returns back into place without any residual marks. Mucous membranes are moist.
2. Hair normally covers all but the soles, palms, inner labial surface (girls) and glans penis (boys).

F. FACE/NOSE/ORAL CAVITY

1. Observe the spacing and size of facial features.
2. The nasal mucosa should be firm and pink.
3. The nose should be in center of face and symmetric, a flattened bridge is sometimes seen in Asian and black children.
4. Both nares should be patent. Nasal hair should be present.
5. The lips intact, pink, and firm.
6. Oral membranes are normally pink, firm, smooth and moist.
7. The buccal cavity, tongue margins and gums appear bluish in black children.
8. The frenulum attaches to the undersurface of the tongue near tip allowing the child to reach the areolar ridge with the tip of the tongue.

9. Teeth - The normal 30 month old has 20 temporary teeth. A child with full permanent dentation has 32 teeth. The upper teeth should slightly override the bottom teeth.
10. Tonsils - If present, tonsils are normally same color as buccal mucosa. They are large in pre-school age children and appear larger as they move toward the uvula. Crypts may be present on their surface. The uvula remains in midline. Upon gagging the uvula moves upward.

G. THORAX/LUNGS

1. The chest is rounder in young children. By 6 years of age the ratio of anteroposterior diameter transverse diameter is about 1:35.
2. In some infants the sternum is so pliant that it appears to cave with each breath.
3. The thorax should move symmetrically.
4. Enlarged breasts can be seen in young infants as a result of hormonal influences.
5. In children younger than 7 respirations are diaphragmatic and the abdomen rises with inspiration. In girls older than 7 years of age breathing becomes thoracic. Abdomen and chest should move together regardless of type of breathing.
6. Resonance is heard over all lung surfaces. Dullness can be heard over the fifth right intercostal space and over the second to fifth left intercostal space.
7. Breath sounds normally seem louder and harsher in infants and young children. Vocal sounds during auscultation are normally heard as indistinct syllables.

H. CARDIOVASCULAR SYSTEM

1. Apical pulse is normally palpable in infants and younger children.
2. S2 is normally loudest in the aortic and pulmonic regions near base of the heart. S2 normally splits upon inspiration in children.
3. S1 and S2 are equal in intensity at ERB's point. S1 is loudest in the mitral and tricuspid regions.
4. Sinus arrhythmias are a normal variant in which rate increases with inspiration and deceases with expiration.

I. VASCULAR SYSTEM

1. Pulse rates will be lower in athletic children and adolescents.
2. Normal pulses are palpable, equal in intensity and even in rhythm.

ABDOMEN:

1. A pot-bellied or prominent abdomen is normal until puberty. The abdomen appears flat when supine.
2. Veins are often visible on the abdomen of the light skinned children.
3. Bowel sounds occur every 10-15 seconds and are heard as gurgles, clicks and growls.
4. Dullness or flatness is normally found along the right costal margin and 1-3cm below costal margin of the liver.
5. Tympany is normally heard throughout the rest of the abdomen.

PALPATATION:

1. The spleen tip can be palpated 1-2cm below left costal margin during inspiration in infants and young children and is felt as a thumb shaped object.
2. The liver can be palpated 1-2cm below the right costal margin during inspiration in infants and younger children. The liver edge is firm and smooth.
3. The sigmoid colon can be palpable as a tender sausage shaped mass in the left lower quadrant. The cecum can be palpated as a soft mass in the right lower quadrant.
4. The anus should contract quickly when stroked.

LYMPH NODES:

1. Small (less than 1cm or 0.5cm) moveable, non-tender nodes are normal in young children.
2. The spleen can be palpated 1-2cm below the left costal margin in infants and children.

J. <u>REPRODUCTIVE SYSTEM</u>

BREAST INSPECTION:

1. Contour and size of breast and changes in the areola indicate sexual maturity. Some difference in size of the breast is usually normal.
2. Nipple inversion is a normal variation and can be present from puberty.
3. Normal young breast tissue has firm elasticity.

FEMALE GENITILIA:

1. Labia should appear pink and moist.
2. Skene's and Bartholin's glands are normally not palpable.
3. Small amount of clear discharge is normal.

MALE GENTILIA:

1. The obese child might appear to have a small penis because of skin folds.
2. The foreskin is normally adherent in children younger than 3 years.
3. The urinary meatus is normally slightly ventral at the tip of the penis and slit like.
4. A pre-puberty boy normally does not have pubic hair.
5. The left testis is lower than the right.
6. A testis should appear to be present in each sac, freely moveable, smooth, equal size and about 1.5cm until puberty. A retractable testis is usually bilateral.

K. MUSCULOSKELTAL SYSTEM

1. Infant and toddlers tend to walk bow-legged. A wide base gait is normal in infants and toddlers.
2. Spine is rounded in the infant younger than 3 months. A lumbar curve forms at 12-18 months. Lumbar lordosis is normal in young children.
3. No resistance or pain should be felt when child bends neck or it is flexed or moved side to side.
4. Strength of upper extremities should be equal.
5. The feet of infants and toddlers are flat and legs bowed until walking is firmly established.
6. Knock knee is present until child is past 7 years of age.
7. Strength should be symmetrical in lower limbs.

L. NERVOUS SYSTEM

1. Motor behavior will vary with the age of the child and stage of development, which is acceptable within the family and cultural norms.
2. Infants and toddlers do not display marked preference for one hand.
3. Infants normally have the most flexible range of motion.

M. DEVELOPMENT

Standard use of PEDS/PSC screening tools for development. (See CH-3 policy Use of PEDS Screening Method in the Evaluation of Developmental Status in Children for further details.)

N. MENTAL HEALTH

1. See above developmental tools.

2. HEADDSS screening tool is used for ages 11-21 for behavioral developmental testing. The CRAFFT is then performed, if indicated, by positive answers on the HEADDSS tool.
3. Patient Health Questionnaire-9 (PHQ-9) screening tool.

O. VITAL SIGNS

1. Weight is assessed as normal by the body mass index (BMI). BMI should be within the 5-85 percentiles for age. All nutritional guidelines are set forth by referencing: *Nutrition Assessment Bright Futures Nutrition*, Third Edition.
2. Normal temperature is afebrile: (See table of normal below.)

Table of Normal

AGE	Fahrenheit
3 months	99.4
1 year	99.7
3 years	99
5 years	98.6
7 years	98.3
9 years	98.1
13 years	97.8

3. Pulse Rates at Rest

	Resting Awake	Resting (asleep)	Exercise/Fever
Birth	100-180	80-160	Up to 220
1-3 months	100-220	80-180	Up to 220
3 month-2 years	80-150	70-120	Up to 200
2-10 years	70-110	60-100	Up to 180
10 years-Adult	55-90	50-90	Up to 180

4. Respirations

AGE	BREATHS/MINUTE
1 year	20-40
3 years	20-30
6 years	16-22
10 years	16-20
adult	12-20

All above material from Mosby's Pediatric Assessment Engel 5th Edition

5. Blood Pressures for 90-95 %

BOYS						GIRLS		
Systolic BP		Diastolic BP		Age Years		Systolic BP		Diastolic BP
98		52		1		98		54
100		55		2		101		58
101		58		3		102		60
102		60		4		103		62
103		63		5		104		64
105		66		6		105		67
106		68		7		106		68
107		69		8		107		69
107		70		9		108		71
108		72		10		109		72
110		74		11		111		74
113		75		12		114		75
120		80		≥13		120		80

2017 AAP Guidelines for Childhood Hypertension

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
POLICY

TITLE: **INCREASING STAFF AWARENESS OF HEALTH LITERACY AND IMPACT ON HEALTH**

DATE DEVELOPED: **5/9/16**
REVIEWED: **6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/17; 6/18**

I. POLICY:

The Division of Public Health Services strives to provide culturally appropriate healthcare to all clients regardless of age, disability, race, culture, socioeconomic status or literacy level. Incorporation of The Bright Futures documentation forms in the Child Health Clinic promotes parent and client engagement in the health decisions and improves health literacy outcomes.

II. PURPOSE:

To increase staff awareness of the impact of health literacy on the health status of the community. To use health literacy strategies to improve communication with parents and clients to improve health outcomes.

III. GUIDELINES:

1. The Staff Development or Clinical Nursing Supervisor will provide/ensure that all new employees will receive training on Health Literacy. All new employees will view the most recent updated powerpoint on Health Literacy. The powerpoint will be updated by the Health Educators and will be presented to all employees every year at annual training. Employees may also wish to complete the free training available at the Centers for Disease Control and Prevention for continuing education credit at the following website: http://www.cdc.gov/healthliteracy/index.html.
2. At a minimum of every two years, each program area will review program data specific to health literacy and its effect on the health status of the community.
3. The agency will apply health literacy strategies to improve health outcomes by using the Bright Futures Tool Resource Kit program required forms which include:

    - Bright Futures Pre-visit questionnaires
    - Visit documentation forms
    - Bright Futures Parent /Patient Education handouts to summarize anticipatory guidance for each child

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

CLINICAL PROCEDURES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
PROCEDURES

TITLE: BLOOD PRESSURE

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/22; 6/24

I. PURPOSE:

To assess systolic and diastolic arterial blood pressure.

II. NURSING CONSIDERATIONS:

A. Assist the client to a comfortable position.

B. If indicated, obtain blood pressure with client in lying, sitting, and/or standing position to evaluate for orthostatic hypotension.

C. Avoid taking blood pressure on an arm that is injured, an arm with a shunt, an arm that is being infused with an intravenous solution, or an arm affected by a mastectomy.

III. EQUIPMENT:

A. Adequate size sphygmomanometer with cuff or automated blood pressure cuff

B. Stethoscope

IV. PROCEDURE:

A. Explain the procedure to the client and caregiver.

B. Assemble the equipment.

C. Determine the proper cuff size to obtain an accurate reading.

D. Expose the client's arm above the elbow. Instruct the client to relax arm. Support the client's forearm.

E. Before the cuff is applied, squeeze out the excess air. Center the arrows marked on the cuff along the brachial artery. Adjust the cuff by placing it over the inner aspect of the arm, approximately one inch above the elbow. The cuff size should encircle 80% - 100% of the arm. The cuff width should be 40% of the circumference of the upper arm.

F. Strap the Velcro sleeve band, and secure firmly. Client's arm should be bare. Support arm horizontally so the cuff is positioned at heart level – the fourth intercostals space.

G. Insert the tips of the stethoscope in your ears, with the ear tips pointing down and forward. Apply stethoscope lightly to the antecubital fossa.

H. Tighten the pressure valve or screw that is located on the bulb.

I. Squeeze the bulb to inflate the pressure cuff until the brachial artery can no longer be **heard**. Then inflate the cuff to a mercury reading of 20 to 30 mm Hg above the point where the pulse disappeared and can no longer be **heard**.

J. Slowly release the pressure valve on the inflation bulb, allowing the mercury to fall at a rate of 2 to 3 mm Hg per second. Listen for pulse sounds.

K. The number that the column of mercury has risen to at the first sound heard in the stethoscope is the systolic blood pressure reading. Continue to release the pressure slowly until the last pulsation is heard or the disappearance of sound. This is the diastolic blood pressure reading.

L. Allow the pressure to fall rapidly to zero, and remove the cuff.

M. If you repeat the procedure wait 30 seconds.

N. Provide client comfort measures.

V. DOCUMENTATION:

Document in notes:

1. Client's blood pressures
2. Notification of report to physician or **Advanced Practice Provider (APP)** of abnormal findings or drastic deviations from baseline.
3. Any teaching instructions discussed and/or provided to the client.

Source: American Heart Association website (http://www.heart.org)

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
PROCEDURES

TITLE: TOPICAL MEDICATIONS

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15

I. PURPOSE:

To apply medication to the skin to improve skin integrity, relief of itching or improved circulation.

II. NURSING CONSIDERATIONS:

A. To prevent accidental exposure to the medication, wear gloves and use applicators as appropriate.

B. Do not apply new medication over old medication or over encrusted areas of dead tissue; this prevents absorption and has little therapeutic effect.

C. Instruct the client/caregiver how to apply topical medication.

D. Avoid excessive application of topical medication; some ingredients can damage sensitive skin.

E. A variety of medications may be applied to the skin, review and follow manufacturer's recommendation to ensure maximum penetration and absorption.

F. Report any significant findings to provider.

III. EQUIPMENT:

A. Medication (cream, powder, patch, ointment, and spray) as ordered by the provider.

B. Cotton-tip applicators or tongue blade.

C. Sterile dressing and hypoallergenic tape if indicated.

D. Soap and warm water, basin, washcloth, towel, protective covering.

E. Non-sterile latex free gloves.

IV. PROCEDURE:

A. Explain the procedure to the client/caregiver. Assess for allergies.

B. Wash hands. Assemble equipment and don gloves.

C. Assist client to comfortable position and drape for privacy.

D. Remove old medication, and prepare the skin or tissue for new medication in the following manner:

1. Wash the skin with soap and water, pat dry.

2. Assess the client's skin condition, making notation of circulation, drainage, color, temperature, or any altered skin integrity.

E. Apply new medication with appropriate applicator and cover with sterile dressing if indicated.

F. Confirm client/caregivers understanding of appropriate medication application.

V. DOCUMENTATION GUIDELINES:

Document the following in the medical record:

1. The procedure and client toleration.

2. Any client/caregiver instructions and compliance with the procedure.

3. Possible adverse effects and symptoms to report.

4. Other pertinent findings.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
PROCEDURES

TITLE: WEIGHT

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/24

I. PURPOSE:

A. To measure weight gain or loss.

B. To assess fluid status or edema.

C. To evaluate compliance with diet and medication regimen.

II. NURSING CONSIDERATIONS:

A. Notify the client's physician or **Advanced Practice Provider (APP)** of a three to four pound weight gain in one week or as specified by provider.

B. Report significant findings to provider.

III. EQUIPMENT:

Scale

IV. PROCEDURE:

A. Explain the procedure and rationale to the client/caregiver.

B. Use the same scale on the same flooring each time the client is weighed if possible.

C. Weigh the client as follows:

1. Have the client center his or her bare feet on the scale and stand erect with feet flat on floor.

2. If it is possible, weigh the client with the same amount of clothing on and at the same time of day each visit (if possible).

3. If possible, use a balance beam or electronic scale to measure weight. Calibrate scales on a regular basis.

D. Read the client's weight indicated on the scale.

E. Provide client comfort measures.

V. DOCUMENTATION:

Document in the medical record:

1. Weight, fluid status, and other pertinent findings.

2. Communication with provider.

Physical Examination and Health Assessment Jarvis, 7th Edition, 2016.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
PROCEDURES

TITLE: INHALATION/NEBULIZER THERAPY

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/24

I. PURPOSE:

A. To administer nebulizer medications.

B. To increase alveolar ventilation and improve cardiopulmonary status.

II. NURSING CONSIDERATIONS:

A. Make sure the nebulizer is kept in an upright position. (If the nebulizer is not level, the medication does not nebulize properly and may spill into the client's mouth).

B. If the client is receiving supplemental oxygen by nasal cannula, leave the nasal cannula on and administer the treatment with compressed air.

C. Consult with the DME vendors regarding recommendations for applications and a model of the appropriate face mask.

D. Report any significant findings to provider.

III. EQUIPMENT:

A. Compressed air or oxygen machine from DME supplier.

B. Medication as ordered by provider.

C. Specimen cup for sputum specimen if ordered.

D. Non-sterile gloves, tissues, trash bag.

E. Face mask if indicated.

IV. PROCEDURE:

A. Explain the procedure to the client/caregiver.

B. Assist the client to a comfortable position.

C. Assess the client's cardiopulmonary status before and after the treatment. Notify the provider if the findings are abnormal or if the client's baseline status deviates.

D. Wash hands, don gloves, don face mask if indicated.

E. Assemble the following equipment at a convenient work area:

1. Fill the nebulizer with the prescribed medication.

2. Turn on the compressed air; a visible mist should flow out of the mouthpiece.

3. Occasionally, aerosol therapy may be given with oxygen; adjust the liter flow between 6 and 8 LPM per provider's orders to obtain a visible mist from the mouthpiece.

F. Administer the following treatment:

1. Instruct the client to insert the mouthpiece and inspire slowly through his/her mouth to facilitate maximum ventilation of the lungs.

2. After each deep inhalation, instruct the client to hold his/her breath briefly to provide maximum absorption of the medication, then exhale.

3. Stay with the client; continue to provide reassurance and encourage slow, deep breaths.

4. Turn the compressor off if the client should have a coughing episode or if the treatment is interrupted for any reason.

5. Evaluate the client's responses to the treatment:

   a. Has the breathing improved?
   b. Does the client feel relief?
   c. Note any signs of dyspnea, wheezing, agitation, tremors, tachycardia, or palpitations.
   d. If any adverse effects occur, stop the treatment and notify the provider to obtain further orders.

G. Turn off the air compressor or oxygen and empty the nebulizer cup after treatment.

H. Encourage the client to cough once the treatment is completed. Provide a specimen cup for sputum if needed.

I. Provide client comfort measures.

J. Instruct client/caregiver to clean and replace the equipment. Place disposable items in trash bag, discard properly, wash hands.

V. DOCUMENTATION:

Document in the medical record:

1. The procedure and client toleration.

2. Cardiopulmonary status.

3. Length of the treatment and medications used and description of secretions.

4. Any client/caregiver instructions and compliance with the procedure, including ability to administer treatment.

5. Communications with physician or **Advanced Practice Provider (APP)**.

The Lippincott Manual of Nursing Practice 10th Edition
Devilbiss Compressor/Nebulizer Instruction Guide

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
PROCEDURES

TITLE: PULSE

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/24

I. PURPOSE:

A. To assess pulse rate, rhythm, and intensity

B. To detect an irregular heart rhythm

C. To detect a pulse deficit

D. To detect tachycardia

II. NURSING CONSIDERATIONS:

A. The radial pulse is commonly used during routine measurements of vital signs.

B. If the radial pulse is irregular or inaccessible, follow the procedure for apical pulse.

C. Report significant findings to physician or **Advanced Practice Provider (APP).**

III. EQUIPMENT:

A. Stethoscope

B. Wrist watch with second hand or digital display

IV. PROCEDURE:

A. Apical pulse:

1. Explain the procedure to the client and caregiver.

2. Assist the client to a supine or sitting position.

3. Expose the chest area.

4. Place the diaphragm over the PMI (point of maximum intensity) and auscultate heart sounds.

5. Using a watch, count the apical pulse for one minute.

6. Provide client with comfort measures.

B. Apical-radial pulse:

1. Follow steps one through four of the procedure for apical pulse.

2. With the other hand, palpate and assess the radial pulse.

3. When the radial pulse can be felt, use a watch and count the apical and radial pulses simultaneously for one minute.

4. Assess any differences between the radial and apical pulses – the pulse deficit. Note the pattern or frequency of any irregularity.

5. Provide client comfort measures.

C. Radial pulse:

1. Follow steps one and two of the procedure for apical pulse.

2. Gently bend the client's elbow to a comfortable angle with the client's wrist extended and palm up. Support the client's lower arm with your arm as needed.

3. Palpate the radial pulse in the following manner:

   a. Exert slight pressure with the tips of your first two fingers on the client's inner wrist and over the radial artery. DO NOT use your thumb.
   b. Obliterate the pulse initially, and then relax, so that the pulse becomes easily palpable.

4. Using a watch, count the pulse for one full minute.

5. Assess the rate, rhythm, and intensity of the radial pulse against your fingertips.

6. Provide client comfort measures.

V. DOCUMENTATION:

Document in the medical record:

1. Characteristics of pulse and heart sounds

2. If a pulse deficit exists, record the actual apical and radial pulses

3. Correlate the pulse characteristics with the prescribed medications and notify the physician or provider of any abnormal finding or deviations from the baseline status.

4. Communication with physician or **APP**.

Seidel's Guide to Physical Examination, 8th Edition
(Mosby's Guide to Physical Examination), 2015

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
PROCEDURES

TITLE: TEMPERATURE

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/21; 6/24

I. PURPOSE:

To assess body temperature.

II. NURSING CONSIDERATIONS:

A. DO NOT take an oral temperature on clients who are disoriented, unconscious, or on oxygen therapy, or on those who have had surgery of the mouth. Consider the axillary procedure or an infrared thermometer.

B. Oral temperature measurement is not used in infants and small children.

C. Report significant findings to provider.

III. EQUIPMENT:

A. Oral, axillary, or infrared (surface) thermometer

B. Tissue

C. Disposable thermometer, plastic sleeves or protective coverings

D. Antiseptic wipes

E. Disposable non-sterile gloves

IV. PROCEDURE:

A. Oral:

1. Explain the procedure to the client/caregiver.

2. Wash hands and assemble equipment.

Thermometer – Digital:

(1) **Apply** disposable probe cover.
(2) Push on/off button.

(3) Place thermometer in client's mouth well under tongue.
(4) Allow the thermometer to remain under tongue until beeping sound is heard or per manufacturer's directions.
(5) Remove the thermometer from the mouth and discard the protective cover.
(6) Read the thermometer.
(7) Clean thermometer with alcohol wipe **when soiled or at least weekly,** wash hands, and return the thermometer to its protective container.
(8) Provide client with comfort measures.
(9) Discard disposable items in a plastic trash bag and secure.

B. Axillary:

1. Use a digital thermometer or Sure Temp Plus thermometer.

2. Place protective cover over digital thermometer and press on/off button or if using Sure Temp Plus load a probe cover by inserting the probe into a probe cover by pressing the probe handle down firmly. Verify or select axillary mode on the instrument display.

3. Dry area under arm and place bulb/end/or probe into the center of client's axilla.

4. Place client's arm across chest.

5. Hold thermometer in place until beeps are heard.

6. Remove thermometer from axilla, discard protective covering, or eject probe cover by firmly pressing the ejection button on the top of the probe and read thermometer.

7. Clean the thermometer with alcohol **if soiled or at least weekly,** then wash hands.

8. Return thermometer to its protective container or probe to probe well.

C. Infrared (surface)

1. Make sure button on the side of the thermometer is set to "body".

2. Depress the trigger one time to turn on the thermometer.

3. Hold the thermometer one inch from the client's bare forehead (make sure no hair or hair accessories are blocking the forehead).

4. Depress the trigger and wait for a beep.

5. Read the screen for the temperature.

6. Wipe the thermometer with an approved cleaning method **if soiled or at least weekly** and wash hands.

7. Return the thermometer to the storage area.

V. DOCUMENTATION:

Document in the medical record:

1. Temperature, route and other pertinent findings.

2. Client/caregiver instructions.

3. Communications with provider.

Reference: Welch Allyn Sure Temp Plus Copyright 2003

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

CLINICAL PATHWAY

TITLE: OFFSITE BLOOD PRESSURE SCREENING PROCEDURE

DATE DEVELOPED: 3/22/12
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/24

I. PURPOSE:

To provide preventive and early detection measures to identify people with high blood pressure levels and refer them for clinical evaluation and treatment as needed.

II. NURSING CONSIDERATIONS:

A. Assess client's medical history and medications.

B. Assess client's family history for hypertension.

C. Assess client for risk factors for hypertension which include diabetes or kidney disease diagnosis, obesity, high fat/calorie diet, physical inactivity, excessive sodium intake, alcohol or cigarette usage/abuse.

III. PROCEDURE:

A. **Advanced Practice Provider (APP),** Medical Office Assistant (MOA) or nurse will place client in a quiet area.

B. May use manual or automated blood pressure cuffs.

C. Prepare client by exposing upper arm and choosing a sphygmomanometer that the bladder of the cuff encircles 80% to 100% of the upper arm. The cuff width should be 40% of the circumference of the upper arm.

D. Place the stethoscope lightly on the antecubital fossa.

E. The cuff pressure should rapidly increase to 30mm Hg beyond point at which radial pulse is no longer **heard**. Rate of descent should be no greater than 2 to 3mm Hg per second.

F. In adults, the systolic and diastolic pressure readings should be identified by the pressures corresponding to the first sound and the disappearance of sound respectively. Disappearance should be confirmed by the listening for 10 to 20mm Hg below the last sound heard.

G. Blood pressure should be measured and recorded on the Blood Pressure Offsite Record (Agency Message Sheet).

H. Classification of BP for adults $\geq$18 years old

Category	Systolic mm Hg	Diastolic mm Hg
Normal	< 120	and < 80
Elevated	120-**129**	**and < 80**
Stage 1 Hypertension	**130-139**	**80-89**
Stage 2 Hypertension	**≥ 140**	**≥ 90**
Hypertensive Crisis	**> 180**	**and/or > 120**

The seventh report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure: the JNC 7 Report; American Heart Association Guidelines for Hypertension.

I. Recommendations for follow-up based on initial set of blood pressure measurements for adults age 18 and over

Initial Screening Blood Pressure (mm Hg)		Follow-up Recommended
Systolic	Diastolic	
< 120	**< 80**	Recheck in **1 year**
120-**129**	**< 80**	Recheck in **3-6 months**
130-139	**80-89**	**Recheck in 1-3 Months**
≥ 140	**≥ 90**	Evaluate or refer to source of care within 1 week
≥ 180	**≥ 120**	Refer for emergency care

J. Referral On Screening:

1. If blood pressure is systolic (≥ **140**) or diastolic (≥ **90**), refer to PCP. If client does not have a PCP, make an appointment (first available) with our APP within 1 week.

2. If blood pressure is above 180/**120** or higher and client has symptoms, immediately call client's PCP or refer to the emergency room if PCP not available.

   Symptoms may include any of the following: weakness, numbness on one side, blurred vision or no vision in one eye, difficulty talking, dizziness, severe headache, SOB, nose bleed, or severe anxiety. If client is symptomatic have client lie quietly in room until emergency services arrive or PCP gives further instructions.
   - Record blood pressure on Blood Pressure Log (available online at www.heart.org).
   - Make referral on bottom of Blood Pressure Log and give client original copy.

Source: American Heart Association website (http://www.heart.org).

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American Heart Association.

My Blood Pressure Log

Name: _____

My Blood Pressure Goal: _____ mm Hg

Instructions:

- Measure your blood pressure twice a day—morning and late afternoon—at about the same times every day.
- For best results, sit comfortably with both feet on the floor for at least two minutes before taking a measurement.
- When you measure your blood pressure, rest your arm on a table so the blood pressure cuff is at about the same height as your heart.
- Record your blood pressure on this sheet and show it to your doctor at every visit.

DATE	AM	PM

DATE	AM	PM

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: RN/LPN COMPLETION OF DEPRESSION ASSESSMENT USING PHQ-9 ASSESSMENT TOOL

DATE DEVELOPED: 12/2016
REVIEWED: 4/17; 4/18; 4/19; 3/29/20; 3/21; 3/22; 6/22; 6/23; 6/24
REVISED: 4/17; 4/19; 3/22; 6/24

I. PURPOSE:

The RN/LPN will complete a depression assessment using the PHQ-9 assessment tool for all clients presenting in the clinic who respond affirmatively to one of two mental health screening questions.

II. NURSING CONSIDERATIONS:

A. RN/LPN staff will ask all PHQ-9 questions of the client and record client responses if the subjective AND objective findings criteria are met.

B. RN/LPN staff will total the PHQ-9 responses given by the client in accordance with form scoring instructions.

C. If the client response total is 4 or less AND the answer to question #9 is zero, no RN/LPN intervention is required.

D. If the client response total is 5-9 AND the answer to question #9 is zero, the RN/LPN staff will provide the client with the following information regarding local resources for counseling and support:

1. For the client choosing to continue her pregnancy, RN/LPN staff will notify the OBGYN provider of client choice of the PHQ-9 score and request the earliest available initial prenatal appointment.

2. **Vaya Health**: 24-Hour call center toll free telephone number AND Behavioral Health Crisis line: **1-800-849-6127. For hearing impaired, dial 711 for NC Relay.**

III. CRITERIA FOR NOTIFYING THE MEDICAL PROVIDER:

Consult with the medical provider or medical director if there is any question about whether to carry out any treatment or other provision of the standing order, or if any of the following circumstances apply:

1. Client response total is 10 or more points on the PHQ-9 assessment tool, OR

2. Client response total is 1 or higher on question #9, OR

3. Client's response to the question "if you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?" is "somewhat difficult," "very difficult," or "extremely difficult."

IV. FOLLOW UP REQUIREMENTS:

RN/LPN staff will implement provider recommendations for clients with response totals of 10 or more points on the PHQ-9 assessment tool OR whose response total is 1 or higher on Question #9 OR whose response to the question "if you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?" is "somewhat difficult," "very difficult," or "extremely difficult."

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: STEREOPSIS

DATE DEVELOPED: 1/23
REVIEWED: 6/23; 6/24
REVISED:

I. PURPOSE:

To identify issues with depth perception in children entering into pre-K or kindergarten classes.

II. NURSING CONSIDERATIONS:

A. Assess client for any obvious amblyopia or strabismus before performing procedure.

B. Only perform procedure in a well-lit area free from distractions.

III. EQUIPMENT:

A. For the Lang Stereotest II: The Lang Stereotest II card.

B. For the Bernell Evaluation of Stereopsis (BEST): The BEST dinosaur version cards.

IV. PROCEDURE:

A. Lang Stereotest II:

1. Explain the procedure to the client and parent/guardian.
2. Hold the Lang Stereotest II card 12-14 inches away from the client, perpendicular to the client.
3. Have the client identify any of the shapes on the card.
4. Client passes if he/she can identify the star and one other shape (does not need to name the shape correctly).
5. Refer the client if the only identified shape is the star.

B. Bernell Evaluation of Stereopsis (BEST):

1. Explain the procedure to the client and parent/guardian.
2. Hold the BEST cards 12-14 inches away from the client, perpendicular to the client.
3. Have the client pinch the dinosaur's nose or hand.

4. Have the client identify what animal is coming out of the circles and what animal is going into the circles for rows A-C.
5. For any missed items, use different terminology such as which one is deeper, or which one sticks out and repeat the procedure.
6. Client passes if pinches the dinosaur above the card and correctly identifies the animals in row A.
7. Refer if client pinches the dinosaur at the level of the card or cannot identify the animals in row A.

V. DOCUMENTATION:

Document in notes:

1. If client passed the stereopsis test or if needs to be referred to optometry.

Source: Instruction manuals for Lang Stereopsis II and Bernell Evaluation of Stereopsis Dinosaur version.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

COMMUNICABLE DISEASE POLICIES
INDEX

ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH AND HUMAN SERVICES

Notification/Procedure Flow Chart for Communicable Disease

Call/report comes in to RCDHHS

↓

Call/report forwarded to the Communicable Disease Control Program Coordinator or backup nurse

↓

CD Nurse completes the appropriate NC EDSS Disease Investigation/Worksheet Forms

↓

Verify the diagnosis: Obtain laboratory confirmation or presumed diagnosis based on association of signs & symptoms or time & place exposure.

↓

Follow the current NC Public Health Communicable Disease Manual guidelines for investigating, control measures, treatment, reporting, and educating the client/community on the disease.

↓

Plan & Implement Controls per CDC guidelines

↓

Single/Isolated Case: The CD Nurse completes NC EDSS report and any necessary surveillance forms.
STOP

Outbreak: Two or more cases related to a single incident
Exception: *A single case of any BT agent, including smallpox, botulism, chemical poisoning, or a novel or Avian influenza virus are considered an outbreak and are reported immediately to NC CDC Branch.*

↓

Activate Epi Team & utilize resources (RCDHHS or County Response Plans). ***Notify NC CDC Branch.***

↓

Develop a hypothesis & Epi-curve. Implement a questionnaire (if not already established).

↓

Develop a case definition for the illness: (clinical, laboratory, time period, & location).
Develop categories: suspect, probable, confirmed, and does not meet case definition.

↓

Keep a line listing of all cases: Include demographics, HCW or CCW status, signs/symptoms, date of onset, lab results & serotype, and required CD report information.

↓

Contact SLPH- Inform them of outbreak & approximate # of samples they will receive.

↓

Plan & Implement Controls: per state/CDC guidelines

↓

Media Control & Public Information: Utilize State and/or CDC approved media resources

↓

Final Step: Prepare a report to be shared with the Board of Health and NC Communicable Disease Control (CDC).

STOP

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMMUNICABLE DISEASE CONTROL PROGRAM POLICY

DATE DEVELOPED: 9/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/20; 6/22

I. POLICY:

The Division of Public Health Services (DPHS) shall maintain a Communicable Disease Program and adhere to the guidance of the North Carolina Communicable Disease Branch (NC CDB) in an effort to reduce morbidity and mortality from communicable diseases that are a significant threat to the public. DPHS shall follow recommended guidelines for detection, tracking, investigation, control measures, education, and care activities to control the spread of communicable diseases and to improve the health of people in Rockingham County. Communicable Disease Program policies will be electronically available to the Regional Communicable Disease Nurse Consultant upon request.

II. PURPOSE:

To provide guidance for staff on expectations and requirements of the communicable disease program and to maximize DPHS's ability to control communicable diseases, to assure reports be investigated in a timely manner so that needed control measures can be rapidly identified and applied.

III. DEFINITIONS:

NC-EDSS- North Carolina Electronic Disease Surveillance System

NCGS- North Carolina General Statute

NCAC- North Carolina Administrative Code

DPH- Department of Public Health

IV. APPLICABLE LAW, RULES AND REFERENCES:

The standard of care for communicable disease services is based upon:

- The current North Carolina Communicable Disease Manual
- 10A NCAC 41A
- NC GS 130A 133-148
- 2011-12 DPH/LHD Consolidated Agreement Addendum

V. RESPONSIBLE PERSONS:

The health director is responsible for assuring compliance with the Agreement Addendum. The Communicable Disease Control Coordinator has delegated oversight responsibility.

VI. PROCEDURES:

A. To be in compliance with the non-negotiable items of the agreement addendum, DPHS shall perform or assure the following:

1. Timely Investigation of Case Reports

Within 30 days of receiving notification of a reportable communicable disease or condition, DPHS will assure that investigation and reporting to the NC Division of Public Health (DPH) is documented in the North Carolina Electronic Disease Surveillance System (NC EDSS) and the North Carolina COVID-19 Surveillance System (NC COVID). Disease events reassigned to the State Disease Registar is complete in accordance with GS 130A-41 and 10A NCAC 41A.0101.

The health director or his/her designee will notify the NC Division of Public Health On-Call Epidemiologist at 919-733-3419 within one hour, any suspected cases of diphtheria, measles, polio, rubella, congenital rubella syndrome, mumps, and report by phone within 24 hours of any suspected cases of pertussis involving high risk settings (such as healthcare or childcare facilities providing care to infants).

2. Staff Training in Communicable Disease Control

a. Within one (1) year of employment, the Communicable Disease Control Coordinator (PHN) will complete the "*Introduction to Communicable Disease Surveillance and Investigation in North Carolina*," course offered by the Technical Assistance and Training Program (TATP) of the NC CDB.
b. The PHN shall attend and participate in the annual communicable disease conference and at least two trainings (e.g., webinars, on-site training) sponsored or supported by the Communicable Disease Control Branch is a required component of the course.
c. DPHS shall assure that at least two PHNs with communicable disease program responsibilities have completed the required course.
d. A DPHS PHN may on a one-time bases challenge the course, but must successfully pass the written challenge exam with a

score of 80% or better and have prior relevant work experience and/or academic course work in communicable disease epidemiology from an accredited school of public health within the last ten years. If the challenge is unsuccessful, the PHN must complete the course.

e. PHNs assigned to communicable disease investigation in a primary or backup role will be oriented to the role of Communicable Disease (CD) Nurse by a Regional TATP Nurse Consultant utilizing the current Communicable Disease Orientation checklist. The DPHS will schedule an orientation with the Regional TATP Nurse Consultant within 3 months of assignment of a new primary or backup CD Nurse.

f. PHNs assigned to the primary role of communicable disease are encouraged to incorporate additional training relevant to communicable disease into their continuing education plans.

3. Use of the NC Electronic Disease Surveillance System, NC EDSS

a. Surveillance reports must be investigated and reported using the NC EDSS (GS 130A-41 and 10A NCAC 41A.0101).

b. To become an authorized user, DPHS staff using NC EDSS must receive training provided by the NC DPH to assure the preservation of reported data and protect the confidentiality of records.

c. Additional training is required in order to use NC EDSS for tuberculosis (TB) reporting and HIV/Syphilis.

d. DPHS shall have a minimum of two staff who have attended and completed NC EDSS training (no training is do be done internally by staff) and the NC COVID system.

e. DPHS must have a minimum of two staff members who are currently "active users" (i.e., the ability to log into system and has not been deactivated) who can access all disease areas within NC EDSS (i.e., STD, CD, VPD, TB and COVID).

f. The Communicable Disease Control Coordinator has delegated oversight responsibility and will regularly monitoring all STD, COVID, and other CD disease events via regular review of NC EDSS and NC COVID events and workflows. This nurse is trained in NC EDSS and NC COVID, and is knowledgeable of the current NC Communicable Disease Manual and the NC Sexually Transmitted Disease Manual.

g. DPHS agrees to have designated staff monitor and manage workflows in a timely manner (optimally, on a twice daily basis however DPHS is not required to monitor workflows on weekends or holidays).

h. RCPHHS shall enter into NC EDSS and NC COVID, in a timely manner, all paper laboratory reports and physician reports it receives. Reports for patients outside the jurisdiction of DPHS should be entered into NC EDSS and NC COVID then transferred electronically to the appropriate jurisdiction. (Reports will not be mailed, faxed or e-mailed.)

i. NC EDSS and NC COVID security will be administered by NC DPH, which includes creating new user accounts and/or disabling/deleting user accounts.

j. Sharing NC EDSS and NC COVID user account information such as user name and password is strictly prohibited. Every NC EDSS user must have his/her own account and a functioning email account so he/she may receive system updates distributed via email.

k. DPHS agrees to notify NC DPH by emailing the NC EDSS Help Desk at NCEDSSHelpDesk@dhhs.nc.gov immediately when a user no longer needs access to NC EDSS and NC COVID, either through attrition or transfer to a position unrelated to Communicable Disease or STD surveillance. DPH reserves the right to disable the accounts of users who are unable to demonstrate competency using NC EDSS and NC COVID software.

l. DPHS shall ensure that users will access NC EDSS and NC COVID from work computers in work offices during normal business hours as NC EDSS and NC COVID contains protected health information. If an exception to these expectations is needed, the DPHS employee must have prior written approval from the Health Director. The employee must use a work-supplied, encrypted device and must follow the data security and confidentiality requirements of the LHD. Using NC EDSS and NC COVID on a public wireless network is always prohibited.

4. Per NCGS 130A-41(b)10, the Local Health Director is responsible for examination, investigation, and control of rabies. LHD clinical staff will provide guidance to persons, utilizing the *North Carolina Rabies Public Health Program Manual*, http://epi.publichealth.nc.gov/cd/lhds/manuals/rabies/toc.html, pertaining to:

   a. Rabies pre-exposure immunization
   b. Human rabies risk assessment
   c. Rabies post-exposure prophylaxis in persons

5. LHD agrees to maintain a policy (see CD-10 *Rabies Prevention and Control)* incorporating all of the aforementioned items. This policy

will be electronically available to Regional Communicable Disease Nurse Consultant by December 1, 2022 and upon request.

6. Per 10A NCAC 41A .0206 (b), DPHS has implemented written infection control (IC) policies. The Staff Development Coordinator has completed the UNC Spice infection control training and directs DPHS infection control activities. Proof of training and IC policies shall be available to the Regional TATP Nurse Consultant upon request. If the designated IC trained registered nurse leaves the employment of DPHS, DPHS shall designate and train another registered nurse per the Agreement Addendum requirements.

B. DPHS shall adhere to established performance measures and reporting requirements:

1. Document disease investigations in NC EDSS and NC COVID. DPHS will re-assign disease events to the state within 30 days of notification of a reportable disease or condition. Follow the current NC Communicable Disease Manual Guidelines for NC EDSS and NC COVID documentation.

2. CD nurses shall complete the CD course within one year of employment or pass the written challenge exam and DPHS shall provide names, hire dates and dates of nurses completing the course to the Regional TATP Nurse Consultant by December 1 and upon request.

3. DPHS shall provide names, email address, telephone number and dates of NC EDSS training to the Regional TATP Nurse Consultant by December 1 and upon request.

4. DPHS shall maintain appropriate program policies and shall provide the Regional TATP Nurse Consultant with an electronic copy of Disease Surveillance, Disease Investigation, and NC EDSS Reporting Policies upon request.

5. Provide the Regional TATP Nurse Consultant with an electronic copy of the rabies pre-exposure immunization, human rabies risk assessment and post-exposure prophylaxis administration policies and any inter-agency agreements annually by December 1 and upon request.

C. Performance Monitoring and Quality Assurance:

1. The Regional TATP Nurse Consultant shall advise DPHS on all aspects of the Communicable Disease Program.

2. The Regional TATP Nurse Consultant will conduct a site visit every

3 years utilizing the TATP Site Visit Assessment Tool. During the site visit, training needs will be identified and arrangements for regionally based continuing education.

3. The Regional TATP Nurse Consultant will use the following tools to monitor performance and assure quality of data:

    a. Remote monitoring by review of NC EDSS and NC COVID data, including reports, workflows, and disease events.
    b. Annual review of staff trained in NC EDSS and NC COVID.
    c. Annual review of nurse completing Introduction to Communicable Disease Surveillance and Investigation Course.
    d. Annual review of policies on CD Surveillance, Investigation, and reporting in NC EDSS and NC COVID.
    e. Annual review of rabies pre-exposure immunization, human rabies risk assessment and post-exposure prophylaxis administration policies and any inter-agency agreements.

4. If the LHD is deemed out of compliance, TATP program staff shall provide technical assistance to bring the LHD back into compliance with deliverables. If technical assistance does not prove beneficial, the CDB will issue a letter of non-compliance and the LHD may lose access to NC EDSS and NC COVID. Non-compliance with this agreement will result in a reduced capacity for the LHD to detect and control communicable disease in the community.

VII. REFERENCE PLANS AND POLICIES:

County Information Technology and Computer Use, 24/7 Response for Communicable Disease, Communicable Disease Training and Staff Development, Investigation of Communicable Diseases and Conditions, Surveillance and Reporting of Communicable Diseases, Communicable Disease Risk Communication, Epidemiology (Epi) Team, and Record Management and Retention Schedule policies.

NC Communicable Disease Manual/Appendices/Policies & Procedures/ Communicable Disease Training &Staff Development, Dec, 2019.

NC Rabies Public Health Program Manual, Feb. 2013.

VIII. FUNDING GUIDELINES OR RESTRICTIONS:

Requirements for pass-through entities: In compliance with *2 CFR § 200.331 – Requirements for pass-through entities*, the Division provides Federal Award

Reporting Supplements to the Local Health Department receiving federally funded Agreement Addenda (AA).

A. Definition: A Supplement discloses the required elements of a single federal award. Supplements address elements of federal funding sources only; state funding elements will not be included in the Supplement. Agreement Addenda (AAs) funded by more than one federal award will receive a disclosure Supplement for each federal award.

B. Frequency: Supplements will be generated as the Division receives information for federal grants. Supplements will be issued to the Local Health Department throughout the state fiscal year. For federally funded AAs, Supplements will accompany the original AA. If AAs are revised and if the revision affects federal funds, the AA Revisions will include Supplements. Supplements can also be sent to the Local Health Department even if no change is needed to the AA. In those instances, the Supplements will be sent to provide newly received federal grant information for funds already allocated in the existing AA.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH AND HUMAN SERVICES
POLICY

TITLE: 24/7 RESPONSE FOR COMMUNICABLE DISEASE

DATE DEVELOPED: 9/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/18; 6/19; 6/22

I. POLICY:

This policy sets the standard for the Division of Public Health Services (DPHS) to respond to reports of communicable disease within its jurisdiction on a 24 hour/7 day a week basis.

II. PURPOSE:

The Division of Public Health Services (DPHS) will investigate and implement control measures for all reports of communicable disease according to local and state laws and in accordance with the recommendations of the Centers for Disease Control and Prevention (CDC).

III. DEFINITIONS:

On-Call Staff - Trained and designated to carry the after-hours pager and cellular phone. For SFHC the Communicable Disease Control Coordinator serves as primary contact, but other professional staff trained to respond may serve as backup.

Key Agency - Locally defined agencies including hospitals, emergency management, and state/regional public health entities.

IV. APPLICABLE LAW, RULES AND REFERENCES:

N.C. G.S. 130A-9 Section .0214; a local health department shall provide services and perform activities for the control of communicable disease within the jurisdiction of the local health department.

V. RESPONSIBLE PERSONS:

The health director is responsible for ensuring that DPHS has the capability to respond to communicable disease events within Rockingham County on a 24 hour/7 day a week basis.

VI. PROCEDURE:

1. The health director will ensure that trained staff is available 24/7 to respond to public health concerns from the community, including private citizens, hospitals, private health care providers, emergency response personnel, correctional facilities, long term care facilities, schools, child care facilities, restaurants, and other government agencies.

2. The health director will ensure that key agencies are informed of the 24/7 policy and will ensure that these agencies are provided with current contact information.

3. The health director will ensure that anyone contacting the department after hours, including nights, weekends, and holidays, will be given instruction on how to reach a health department representative for emergencies.

4. The Communicable Disease (CD) Control Coordinator will be available 24/7 for emergency response. The Public Health Preparedness Coordinator will serve as back-up.

5. The health director, CD Coordinator and backup will be available for response by a minimum of three means of contact: a work telephone number, a home/cellular phone number, and e-mail.

6. Staff on call for emergency response for communicable disease will have available a cellular phone for responding to calls.

7. Staff on call for communicable disease response will have access to DPHS' facilities after hours.

8. Staff on call will have access to the NC Health Alert Network and be able to communicate via email, fax and telephone with public health professionals and other key agencies.

9. Staff on call will be available to respond within 20 minutes to an after-hours emergency voicemail message.

VII. OPERATIONS:

1. Normal Working Hours – Monday through Friday, 8:00 am - 5:00 pm. The CD Coordinator has primary duty for communicable disease calls after hours. On-Call contact numbers are as follows:

Staff Member	Office	Work Cell	Home	Email
Susan Young, RN, BSN Nursing Director	336-342-8151	N/A	336-951-7549	syoung@co.rockingham.nc.us
Jennifer Thomas, RN CD Control Coordinator	336-342-8163	336-589-5715	336-616-7040	jsthomas@co.rockingham.nc.us
Charlotte Martin, RN PHP Coordinator	336-342-8241	336-589-5680	336-420-5408	cmartin@co.rockingham.nc.us

2. On-Call Service**:** Carolina Access at 1-336-589-5728, caller shall give the following information:

   a. The name of the suspected or confirmed communicable disease.
   b. Name of the attending physician.
   c. Name, title, and telephone number of the reporting individual.

VIII. REFERENCE PLANS AND POLICIES:

County Government Compensatory Time, Communicable Disease Program, Communicable Disease Training and Staff Development, Investigation of Communicable Diseases and Conditions, Surveillance and Reporting of Communicable Diseases, Communicable Disease Risk Communication, Epidemiology (Epi) Team, and Record Management and Retention Schedule policies.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH AND HUMAN SERVICES
POLICY

TITLE: COMMUNICABLE DISEASE TRAINING AND STAFF DEVELOPMENT

DATE DEVELOPED: 9/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/22

I. POLICY:

The Division of Public Health Services (DPHS) will maintain a minimum of two nurses trained in communicable disease. The Communicable Disease (CD) Control Coordinator, Public Health Preparedness Coordinator (designated back up nurse) and Clinical Nurse Supervisor shall complete the *Introduction to Communicable Disease Surveillance and Investigation in North Carolina* course or successfully complete the challenge exam and receive orientation by the Regional CD Nurse Consultant. The CD Control Coordinator and back-up shall and have additional training in the North Carolina Electronic Disease Surveillance System (NC EDSS) and NC COVID.

The Communicable Disease Control Coordinator and designated backup staff shall have access to computer hardware and software and related technical training as needed to ensure that they can perform their job responsibilities in both paper-based and electronic environments.

The Communicable Disease Control Coordinator shall attend annually required and periodical educational opportunities such as workshops, meetings and classes to keep skill sets current.

II. PURPOSE:

To define minimum required training and staff development activities for public health nurses with responsibility for communicable disease surveillance, investigation, control measures, and reporting.

III. DEFINITIONS:

On-Call Staff **-** trained and designated locally to carry the after-hours pager and cellular phone. For DPHS the Communicable Disease Control Coordinator serves as primary contact, but other professional staff trained to respond may serve as backup.

Key Agency - Locally defined agencies including hospitals, emergency management and state/regional public health entities.

IV. APPLICABLE LAW, RULES AND REFERENCES:

N.C. G.S. 130A-9 Section .0214; a local health department shall provide services and perform activities for the control of communicable disease within the jurisdiction of the local; health department.

V. RESPONSIBLE PERSONS:

The health director is responsible for ensuring that DPHS has appropriately trained communicable disease staff with the capability to respond to communicable disease events within Rockingham County.

VI. PROCEDURE:

1. The health director or nursing director shall request enrollment for public health nurses in specified courses/trainings during the first month of employment.
2. The health director shall annually budget funds for travel related expenses for training and staff development specific for the communicable disease staff.
3. The health director or supervisor will provide work time for public health nurses to complete required trainings, or provide compensatory time for employees that may negotiate to complete requirements outside of regularly scheduled work hours.
4. Public health nurses who register for required training and fail to complete the course may be charged the current course fee if they do not have permission from the course instructor to drop.
5. Annually or as staffing changes, the health director or person with supervisory responsibilities for the communicable disease program will inform the NC General Communicable Disease Control Branch of all public health nurses who would be affected by this policy.

VII. REFERENCE PLANS AND POLICIES:

Communicable Disease Program, 24/7 Response for Communicable Disease, Investigation of Communicable Diseases and Conditions, Surveillance and Reporting of Communicable Diseases, Communicable Disease Risk Communication, Epidemiology (Epi) Team, and Record Management and Retention Schedule policies.

NC Communicable Disease Manual/Appendices/Policies & Procedures/Communicable Disease Training &Staff Development, Nov. 2012.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
POLICY

TITLE: INVESTIGATION OF COMMUNICABLE DISEASES AND CONDITIONS

DATE DEVELOPED: 9/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/20

I. POLICY:

The Division of Public Health Services (DPHS) will investigate all reports of communicable disease according to local and state laws and in accordance with the recommendations of the Centers for Disease Control and Prevention.

II. PURPOSE:

This policy sets the standard for the Division of Public Health to investigate suspect cases of communicable diseases and conditions within its jurisdiction.

III. DEFINITIONS:

Communicable Disease- an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or though the inanimate environment. *NCGS 130A-2 (1b)*

Communicable Condition- the state of being infected with a communicable agent, but without any symptoms. *NCGS 130A-2 (1a)*

IV. APPLICABLE LAW, RULES AND REFERENCES:

The authority for this policy is derived from:

- NCGS ∫130A-41(b)
- NCGS 130A -144
- 10A NCAC 41A .0103 and .0101
- 10A NCAC 41A .0201 through .0205

V. RESPONSIBLE PERSONS:

The health director is responsible for ensuring that DPHS investigates all reports of communicable disease and for the enforcement of communicable disease laws in Rockingham County. The health director has designated the Communicable Disease Control Coordinator as the responsible person for the communicable disease program.

VI. PROCEDURE:

1. The health director will assure that trained staff is available 24/7 to investigate reports of communicable diseases and conditions from the NC Division of Public Health, hospitals, private health care providers, emergency response personnel, correctional facilities, long term care facilities, schools, child care facilities, restaurants, other government agencies, and private citizens, schools, child care facilities, restaurants, and other government agencies.

2. The health director has designated the Communicable Disease Control Coordinator to be responsible for the DPHS communicable disease program.

3. The health director will assure that all staff who have direct responsibility for communicable disease/condition investigation have educational preparation (formal and/or continuing education) to perform public health disease investigations. At least two (2) staff members will be assigned this responsibility. Within one (1) year of employment, Public Health Nurses with responsibility for disease surveillance and investigation will complete the course "*Introduction to Communicable Disease Surveillance and Investigation in North Carolina*".

4. The health director or his/her designee will ensure that control measures have been implemented for each case in accordance with GS130A-144, 10A NCAC 41A .0201 CONTROL MEASURES - GENERAL, 10A NCAC 41A .0202 CONTROL MEASURES- HIV, 10A NCAC 41A .0203 CONTROL MEASURES - HEPATITIS B, 10A NCAC 41A 0204 CONTROL MEASURES - SEXUALLY TRANSMITTED DISEASES and 10A NCAC 41A .0205 CONTROL MEASURES - TUBERCULOSIS.

5. Disease investigations shall generally begin by first contacting the physician of record for additional information. If there is no physician of record, or if the physician of record does not respond to requests for information promptly, or if the physician is not able to provide complete disease investigation information, then individuals may be contacted.

6. When efforts to investigate a report of communicable disease have been made and insufficient information has been obtained to complete the investigation, the health director, or his/her designee shall report the case with the information that has been received and document the investigation attempts. With the exception of HIV/Syphilis and TB investigations which will follow their specific program guidance regarding investigations, the minimum effort to investigate diseases are as follows:

    a. High Profile Diseases (Category A Diseases, Hepatitis A, & N. Meningitidis) – Individual cases within this category should be

investigated immediately. Termination of the investigation should only be made in consultation with NC DPH epidemiologist.

b. Bacterial STDs – At least 3 attempts to investigate the reported disease. One attempt must be through written correspondence to the provider. If provider fails to respond, contact the patient and verify that the patient received appropriate treatment.

c. Hepatitis B Acute, Chronic, Lab/Condition Report: At least 3 attempts to contact the provider, one of which must have been through written correspondence. Patients should not be contacted until at least one attempt to reach the provider has been made. The public health nurse should make at least 3 attempts to contact the patient regarding contacts and control measures before assigning the event to the state.

- Exception: Hepatitis B lab/condition reports may be assigned to the state without contacting the provider or patient.
- Please refer to the HBV Business Rules for guidance.

d. Foodborne and Diarrheal Disease – At least 3 attempts to contact the provider, one of which must have been through written correspondence, and 3 attempts to contact the patient regarding food history and exposure.

e. Hepatitis C - At least 3 attempts to contact the provider, one of which must have been through written correspondence, and 3 attempts to contact the patient regarding risk history and public health control measures.

f. Bacterial, Vectorborne, Viral and Zoonotic Diseases - At least 3 attempts to contact the provider, one of which must have been through written correspondence.

g. The health director or his/her designee will contact the NC Division of Public Health On-Call Epidemiologist in cases of:

- unusual public interest
- when coordination with the North Carolina State Laboratory of Public Health or Centers for Disease Control (CDC) is required, or
- if additional guidance on a disease or control measure is needed.

h. The health director or his/her designee will notify the NC Division of Public Health On-Call Epidemiologist at 919-733-3419 within one hour, any <u>suspected</u> cases of diphtheria, measles, polio, rubella, congenital rubella, syndrome, mumps, and report by phone within 24 hours of any <u>suspected</u> cases of pertussis involving high risk settings (such as healthcare or childcare facilities providing care to infants).

7. Nothing in this policy shall prohibit a health director or his/her designee from implementing public health control measures for a suspect case while

a disease investigation is in progress. Reportable diseases and conditions can be found in 10A NCAC 41A .0101.

8. Nothing in this policy shall prohibit a health director or his/her designee from investigating an outbreak of a disease or condition that occurs which is not required to be reported, but which represents a significant threat to the public health.

VII. ENFORCEMENT

1. Communicable disease rules shall be enforced as provided under the North Carolina General Statutes.

2. Steps of enforcement shall include:

   - Seeking voluntary compliance through education first.
   - Issue written orders as appropriate.
   - Document evidence of noncompliance.
   - Consult legal assistance of the County or District Attorney as appropriate.

   Note: The NC Attorney General or University of North Carolina at Chapel Hill School of Government may be consulted when legal assistance is indicated to interpret laws or rules.

3. NCGS 130A-145 Isolation and quarantine authority
   NCGS 130A-145(d) Due process rights of isolation or quarantine law

4. Violations may be enforced using civil or criminal legal remedies.

   - Civil G.S. 130A-18- an injunction (order) filed in Superior Court for person to comply. The person may be charged with failure to comply or contempt of court.
   - Criminal G.S. 130A-25- person charged with a misdemeanor and may be sentenced for up to two years as a health law violator.

5. NCGS 130A-143 authorizes disclosure to court officials for purposes of enforcing communicable disease laws.

   - DPHS will work with attorney and court officials to limit the amount of information entered into public court records.

VIII. REFERENCE PLANS AND POLICIES:

HIPAA, Communicable Disease Program, 24/7 Response for Communicable Disease, Communicable Disease Training and Staff Development, Surveillance and

Reporting of Communicable Diseases, Communicable Disease Risk Communication, Epidemiology (Epi) Team, and Record Management and Retention Schedule policies.

NC Communicable Disease Manual/Appendices/Policies & Procedures/Communicable Disease Training &Staff Development, Dec. 2019.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SURVEILLANCE OF COMMUNICABLE DISEASES AND CONDITIONS

DATE DEVELOPED: 9/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/20

I. POLICY:

The Division of Public Health Services (DPHS) will conduct surveillance for reportable communicable diseases and conditions according to local and state laws and in accordance with the recommendations of the Centers for Disease Control and Prevention.

II. PURPOSE:

This policy sets the standard for the Division of Public Health Services (DPHS) to engage in communicable disease surveillance and reporting within DPHS's jurisdiction.

III. DEFINITIONS:

***Active surveillance*:** the ongoing systematic collection and analysis of data about a specific disease or condition where the information is collected in real time by a trained observer.

***Passive surveillance*:** the ongoing systematic collection and analysis of data about an infectious disease as reported by health care providers in the routine practice of medical care.

***Surveillance staff*:** communicable disease program staff (communicable disease nurse, data entry clerks, clinicians, epidemiologists, etc.)

IV. APPICABLE LAW, RULES and REFERENCES:

The authority for this policy is derived from NCGS ∫130A-5 (Duties of the Secretary) and 130A-41∫ (Powers and duties of local health director) and 10A NCAC 41A (Communicable Disease Control).

V. RESPONSIBLE PERSONS:

The health director is responsible for ensuring that RCDPH performs communicable disease surveillance and completes timely reporting of events within Rockingham County. The Communicable Disease Control Coordinator serves as the primary designated surveillance and reporting staff member. The Public Health Preparedness Coordinator shall serve as back-up.

VI. PROCEDURE:

1. The health director will assure that trained surveillance staff is available to conduct active and passive surveillance for reportable diseases and conditions and other diseases affecting the public's health.

2. Surveillance staff will be able to function in both paper-based and NC EDSS environment.

3. Surveillance staff will notify and inform all health care providers in Rockingham County of the duty to report communicable diseases.

4. Staff will educate health care providers in Rockingham County as to the method of reporting communicable diseases to DPHS and provide them with access to the necessary reporting forms.

5. The health director will assure that the staff has a secure facility equipped with the electronic technology required for surveillance activities.

6. The health director may request regional, state, and/or federal resources to assist in communicable disease surveillance and reporting, especially during outbreaks of communicable disease.

7. Immediate investigation of reportable diseases and conditions will be followed by prompt reporting to the NC Division of Public Health (DPH). Some diseases are immediately reportable to the DPH by telephone, others within 24 hours of report to SFHC, and others within 7 days. For reporting rules refer to NCAC 10A NCAC 41A .0101 and .0103.

8. Staff will analyze surveillance data quarterly during epi team meetings and report annually to the BHHS on disease trends. Data will be used to monitor health status of the community and implement public health control measures as needed.

VII. REFERENCES PLANS AND POLICIES:

Communicable Disease Program, 24/7 Response for Communicable Disease, Communicable Disease Training and Staff Development, Investigation of Communicable Diseases and Conditions, Communicable Disease Risk Communication, Epidemiology (Epi) Team, and Record Management and Retention Schedule policies.

NC Communicable Disease Manual/Appendices/Policies & Procedures/Communicable Disease Training &Staff Development, Dec. 2019.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: REPORTING OF COMMUNICABLE DISEASES AND CONDITIONS

DATE DEVELOPED: 9/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/20; 6/22

I. POLICY:

The Division of Public Health Services (DPHS) will report communicable diseases according to local and state laws and in accordance with the recommendations of the Centers for Disease Control and Prevention.

II. PURPOSE:

This policy sets the standard for DPHS to report cases of communicable diseases and conditions within its jurisdiction.

III. DEFINITIONS:

CD- Communicable Disease
NCAC- North Carolina Administrative Code
NC-EDSS- North Carolina Electronic Disease Surveillance System
NCGS- North Carolina General Statute

IV. APPLICABLE LAW, RULES and REFERENCES:

The authority for this policy is derived from NCGS ∫130A-41(b) and 10A NCAC 41A .0103 and .0101.

V. RESPONSIBLE PERSONS:

The health director is responsible for ensuring that DPHS reports communicable diseases and completes timely reporting of events within Rockingham County. The Communicable Disease Control Coordinator serves as the primary designated reporting staff member. The Public Health Preparedness Coordinator shall serve as back-up.

VI. PROCEDURE:

1. The health director will assure that trained staff is available to report communicable diseases and conditions to NC Division of Public Health utilizing the North Carolina Electronic Disease Surveillance System (NC EDSS) and NC COVID. All DPHS staff using NC EDSS and NC COVID must receive training provided by DPH. Additional training is required in order to use NC EDSS for tuberculosis (TB) reporting and HIV/Syphilis.

2. The health director will assure adequate staff to ensure timely reporting of cases investigated by the health department. Reports will be assigned to the NC Division of Public Health (DPH) via the NC EDSS and NC COVID within one (1) month of notification of the reportable disease or condition. A minimum of two (2) staff will be assigned this responsibility to ensure continuity if the primary staff is not available to report. Active users must have the ability to log into the NC EDSS and NC COVID system.

3. The health director will assure dedicated computers, internet access and IT support for the reporting of communicable disease cases via the NC EDSS and NC COVID system.

4. The health director has designated the Communicable Disease Control Coordinator to be responsible for monitoring all STD and other CD disease events via regular review of NC EDSS and NC COVID events and workflows. The Communicable Disease Control Coordinator must have NC EDSS and NC COVID training and be an active user, and be knowledgeable of the current NC Communicable Disease Public Health Program Manual and the current NC Sexually Transmitted Disease Public Health Program Manual.

5. The health director, or his/her designee, will assure NC EDSS and NC COVID workflows are monitored and managed in a timely manner (optimally, on a twice daily basis).

6. The health director, or his/her designee, will assure that all paper laboratory reports and physician reports of suspected communicable diseases are manually entered into NC EDSS and NC COVID. Reports for patients outside the jurisdiction of DPHS should be entered into NC EDSS and NC COVID then transferred electronically to the appropriate jurisdiction. (Reports will not be mailed, faxed or e-mailed.)

7. Sharing NC EDSS and NC COVID user account information such as user name and password is strictly prohibited. Every NC EDSS and NC COVID user must have his/her own account. Every user must have a functioning email account so he/she may receive system updates distributed via email.

8. The health director or Nursing Director agrees to notify DPH immediately when a user no longer needs access to NC EDSS and NC COVID, either through attrition or transfer to a position unrelated to CD or STD surveillance. DPH reserves the right to disable the accounts of users who are unable to demonstrate competency using NC EDSS or NC COVID software.

9. This policy will be electronically available to Regional Communicable Disease Nurse Consultant upon request.

VII. REFERENCES:

10A NCAC 41A .0103
Division of Public Health Agreement Addendum 510 – Communicable Disease Control
Communicable Disease Program, 24/7 Response for Communicable Disease, Communicable Disease Training and Staff Development, Surveillance of Communicable Diseases and Conditions, Investigation of Communicable Diseases and Conditions, Communicable Disease Risk Communication, Epidemiology (Epi) Team, and Record Management and Retention Schedule policies.

NC Communicable Disease Manual/Appendices/Policies & Procedures/Communicable Disease Training &Staff Development, Dec. 2019.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMMUNICABLE DISEASE RISK COMMUNICATION

DATE DEVELOPED: 6/11
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/20

I. POLICY:

Risk communication is a component of every disease investigation. It is an important control measure in most high-profile cases and in outbreaks of communicable disease. The Division of Public Health Services (DPHS) shall make training available to designated staff to function as part of state-wide team of risk communicators. The Division of Public Health Services' Crisis Communication Plans will be consistent with state level preparedness plans developed by the NC Division of Public Health.

II. PURPOSE:

This policy describes the Division of Public Health Services' plan for risk communication in outbreaks of communicable disease.

III. DEFINITIONS:

Crisis Communication Plan- Guidance document for dissemination of public information during outbreak or high-profile investigations of communicable disease.

High-Profile Case- well known by most and that garners a lot of media or public attention.

IV. APPLICABLE LAW, RULES AND REFERENCES:

N/A

V. RESPONSIBLE PERSONS:

The health director or designated Public Information Officer (PIO) is responsible for ensuring appropriate and accurate public information is disseminated to the public during outbreaks or high-profile cases.

VI. PROCEDURE:

1. The health director or his/her designee will be the official spokesperson for the Division of Public Health Services in matters related to communicable disease cases and outbreak investigations.

2. The spokesperson will be knowledgeable of DHHS/SFHC Crisis Communication plans.

3. The spokesperson will be a member of the EPI Team.

4. The spokesperson will be responsible for developing, distributing, and updating talking points daily during outbreaks or high profile cases.

5. Talking points will address:

    - What is happening
    - Who is affected
    - When, where and why it occurred
    - What the health department is doing about the situation
    - Who else is addressing the problem
    - When additional information will be available
    - What actions individuals can take to reduce their risk
    - Who can be contacted for additional information or concerns

6. Develop press releases, letters and memos for release, using the talking points.

7. Serve as the only point of contact for requests from the media.

8. Assure public health information is disseminated to health care providers and community partners.

9. In widespread outbreaks or situations where joint operations are being conducted, the health department will coordinate release of information with other agencies.

10. Coordinate messages with law enforcement during bioterrorism events.

11. Maintain patient privacy in accordance with HIPAA and other applicable privacy statutes and rules.

VII. REFERENCE PLANS & POLICIES:

Communicable Disease Program, 24/7 Response for Communicable Disease, Communicable Disease Training and Staff Development, Investigation of Communicable Diseases and Conditions, Surveillance and Reporting of Communicable Diseases, Epidemiology (Epi) Team, and Record Management and Retention Schedule, Confidentiality, and HIPAA policies.

NC Communicable Disease Manual/Appendices/Policies & Procedures/Communicable Disease Training &Staff Development, Dec. 2019.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EPIDEMIOLOGY (EPI) TEAM POLICY

DATE DEVELOPED: 9/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/16; 6/17; 6/20

I. POLICY:

The Division of Public Health Services (DPHS) shall have a multidisciplinary epidemiology (EPI) team to manage the public health response to a communicable disease outbreak or other public health threat when surge capacity is needed.

II. PURPOSE:

To define the epidemiology team's role in investigating suspect cases of communicable diseases and conditions within Rockingham County.

III. DEFINITIONS:

Communicable disease - an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or though the inanimate environment. *NCGS 130A-2 (1b)*

Communicable condition - the state of being infected with a communicable agent, but without exhibiting any symptoms. *NCGS ∫130A-2 (1a)*

Key agency - The Division of Public Health Services considers locally defined agencies to include Morehead Memorial Hospital, Annie Penn Hospital, Rockingham County Emergency Medical Services, Rockingham County Emergency Management, and state/regional public health entities as key agencies.

Outbreak - means an occurrence of a case or cases of a disease in a locale in excess of the usual number of cases of the disease.

Isolation authority - means the authority to limit the freedom of movement or action of a person or animal with a communicable disease or communicable condition for the period of communicability to prevent the direct or indirect conveyance of the infectious agent from the person or animal to other persons or animals who are susceptible or who may spread the agent to others.

***Quarantine authority* -** means the authority to limit the freedom of movement or action of persons or animals which have been exposed to or are reasonably suspected of having been exposed to communicable disease or communicable condition for a period of time as may be necessary to prevent the spread of that disease. The term also means the authority to limit the freedom of movement or action of persons who have not received immunizations against a communicable disease listed in G.S. 130-152 when the local health director determines that such immunizations are required to control an outbreak of that disease.

***NCGS* -** North Carolina General Statutes

***NCAC* -** North Carolina Administrative Code

IV. APPLICABLE LAW, RULES, AND REFERENCES:

The authority for this policy is derived from NCGS ∫130A-41(b) and 10A NCAC 41A .010 communicable Disease Rules, January 1996. Chapter 19 – Health Epidemiology, Subchapter 19A – Communicable Disease Control, Section .0100 – Reporting of communicable Disease, Section .0200 control Measures – General, and Section .0300 special Control Measures.

V. RESPONSIBLE PERSONS:

The health director, Communicable Disease Control Coordinator, and the EPI-team.

VI. PROCEDURES:

The health director will appoint an EPI team leader. DPHS EPI team members shall be multidisciplinary and shall include, but are not limited to, health department employees from administration (health director), nursing (supervisor/communicable disease nurse), preparedness coordinator, environmental health specialist, communications (health educator/public information officer), and laboratory staff. Non-health department employees (key agencies) shall be included in training activities and events appropriate to their respective interests and responsibilities.

EPI Team Activities-

1. Prepare for public health response to communicable disease outbreaks and other public health threats through regular meetings and planned exercises.
2. Respond to outbreaks of communicable disease and public health threats when activated by the health director or designee.

3. Orient all health department employees to the responsibilities of the EPI team.
4. The EPI team shall work to strengthen collaborative relationships with key agencies and community partners to enhance community response to public health threats.
5. The EPI team may periodically review epidemiological data to assist in formulating program direction based upon consideration of sound epidemiological principles and recommend actions to prevent or reduce public health threats within the community.

EPI Team Leader Activities –

1. Schedule all EPI team meetings and publish agenda in advance of meeting.
2. Assess skill sets of individual EPI team members and assign roles accordingly.
3. Recommend specific training opportunities/courses to reduce deficiencies in skill sets of individual members.
4. Prepare an after action review and/or outbreak summary report within 30 days of team's de-activation.
5. Prepare an annual summary report for the Board of Health and Human Services (BHHS) of EPI team activities.
6. Keep contact information current in NC Health Alert Network (HAN) Information Exchange.

EPI Team Member Responsibilities –

1. Prepare in advance for activation by making personal arrangements for extended work hours on very short notice.
2. Participate in training opportunities and cross-train with other team members to enhance EPI team capacity to respond.
3. Keep contact information current in RCDPHS telephone tree.

Communicable Disease Control Coordinator Responsibilities –

1. Routine investigations of communicable disease will normally be performed by the Communicable Disease Control Coordinator or back-up nurse.
2. Communication between the health department, NC Communicable Disease Control Branch, private physicians, hospital and occupational infection control personnel will be directed by the Communicable Disease Control Coordinator.

3. The Communicable Disease Control Coordinator shall electronically report to the state within the current Agreement Addendum time-lines for reporting.
4. Ensure that completed reports are stored in the secured medical records room.
5. Ensure that referral and follow up is performed in accordance with the current North Carolina Communicable Disease Manual.

Health Director Responsibilities –

1. Has ultimate responsibility for the DPHS communicable disease control program.
2. The health director or his designee may implement public health control measures for a suspect case while a disease investigation is in progress.
3. The health director or his designee may investigate an outbreak of a disease or condition that occurs which is not required to be reported, but which represents a significant threat to the public health.

VII. REFERENCE PLANS AND POLICIES:

Agency Confidentiality, HIPAA, Communicable Disease Program, 24/7 Response for Communicable Disease, Communicable Disease Training and Staff Development, Investigation of Communicable Diseases and Conditions, Surveillance and Reporting of Communicable Diseases, Communicable Disease Risk Communication, and Record Management and Retention Schedule policies.

The current online NC Communicable Disease Manual/Appendices/Policies & Procedures/Communicable Disease Training &Staff Development, Dec. 2019.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMMUNICABLE DISEASE RECORD MANAGEMENT & RETENTION SCHEDULE

DATE DEVELOPED: 6/11
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/20; 6/22

I. POLICY:

The Division of Public Health Services (DPHS) shall maintain and store communicable disease records in a system that allows records to be retrievable for historical, public health, and risk management purposes. DPHS will adhere to the policies and recommendations of the NC Department of Cultural Resources for local government record management.

II. PURPOSE:

This policy sets standards for the retention of communicable disease records.

III. DEFINITIONS:

N/A

IV. APPLICABLE LAW, RULES AND REFERENCES:

N/A

V. RESPONSIBLE PERSONS:

The Communicable Disease Control Coordinator and the medical records supervisor shall be responsible for ensuring communicable disease records are stored according to established DPHS guidelines.

VI. PROCEDURE:

1. The Communicable Disease Control Coordinator in consultation with the medical records supervisor will be responsible for managing communicable disease records.
2. Communicable disease records will be retained in accordance with the communicable disease record retention schedule.
3. When applying this policy to record retention, the Communicable Disease Control Coordinator shall be careful to distinguish between medical records and communicable disease program records.
4. The Communicable Disease Control Coordinator shall be aware that:

- A communicable disease record is not necessarily a medical record.
- A communicable disease record usually contains secondary sources of medical information that are not subject to HIPAA when used for communicable disease surveillance and investigation purposes.
- Communicable disease records may include both administrative and clinical information in paper-based and electronic formats.
- If DPHS is the health care provider for the communicable disease or condition being treated, the records are part of the medical record.

5. The DPHS medical provider shall report the case as any NC health care provider and a communicable disease record shall be generated.
6. Paper-based communicable disease reports will be separated according to reports that are reported to the state, and to reports that are not reported to the state. These records may contain morbidity cards/forms, physician notes, hospital records, laboratory reports, diagnostic studies, copies of surveillance forms, and nursing notes.
7. Paper-based communicable disease records determined to meet case definition will be documented in the client's medical record (chart), if any, and then stored with other communicable disease records in alphabetical or chronological files by disease and by the year of report to the state.

VII. RECORD RETENTION SCHEDULE:

GENERAL COMMUNICABLE DISEASES/CONDITIONS*

*Does not include Vaccine Preventable Diseases and STD/HIV/AIDS Diseases and Conditions

1. Disease investigation records including all supporting documents for the following diseases/conditions shall be kept indefinitely for the purpose of historical usefulness:

Anthrax
Botulism
Brucellosis
Cholera
Creutzfeldt-Jakob Disease
Hantavirus infection
Hemorrhagic fever virus infection
Influenza virus infection causing death (< 18 years of age)
Influenza, NOVEL virus infection
Leprosy (Hansen's Disease)
Monkeypox
Plague

Q fever
Rabies, human
SARS (coronavirus infection)
Smallpox
Trichinosis
Tularemia
Typhoid Fever, acute
Typhoid, carriage (Salmonella typhi)
Vaccinia
Yellow fever

2. Disease investigation records including all supporting documents shall be kept indefinitely for all reportable communicable diseases that result in death due to that disease/condition.

3. Disease investigation records including all supporting documents for the following diseases/conditions shall be kept for a minimum of five years:

Campylobacter infection
Cryptosporidiosis
Cyclosporiasis
Dengue
Ehrlichiosis, HGE
Ehrlichiosis, HME
Ehrlichiosis, unspecified
Encephalitis, arboviral, EEE
Encephalitis, arboviral, LAC
Encephalitis, arboviral, other
Encephalitis, arboviral, WNV
Escherichia coli - shiga toxin producing
Foodborne diseases: c. perfringens
Foodborne diseases: other/unknown
Foodborne diseases: staphlococcal
Haemophilus influenzae, invasive disease
Hemolytic-uremic syndrome/TTP
Hepatitis A
Hepatitis C, acute
Legionellosis
Leptospirosis
Listeriosis
Lyme Disease
Malaria
Meningitis, pneumococcal
Meningococcal disease, invasive
Psittacosis

Rocky Mountain Spotted Fever
S Aureus, reduced susceptibility to vancomycin
Salmonellosis
Shigellosis
Streptococcal infection, Group A, invasive
Toxic Shock Syndrome, non-streptococcal
Toxic Shock Syndrome, Streptococcal
Typhus (epidemic typhus)
Vibrio infection (not cholera & not vulnificus)
Vibrio vulnificus
VRE (Vancomycin Resistant Enterococci)

4. Communicable Disease Outbreak Investigation Records - Records concerning actions taken by local health directors and public health nurses to control the spread of a communicable disease. Records include copies of letters of notification of exposure sent out to child care facilities, restaurants, etc., outbreak summary reports, after action reports, and other related records. See the following disposition instructions:

   a) Enter all required information for cases and contacts into the North Carolina Electronic Disease Surveillance System (NC EDSS) or NC COVID. Any documents that are part of the investigation should be attached to the corresponding outbreak event in NC EDSS or NC COVID for retention. NC EDSS and NC COVID records are not scheduled for expiration or destruction at this time. Paper records may be destroyed once pertinent information is entered into NC EDSS.
   b) Destroy records supporting the expenditure of federal funds passed through NC DHHS on a fiscal year basis when the DHHS Office of the Controller provides written guidance that records are released from all audits and other official actions.[1]
   c) Destroy in office after 10 years paper records not entered into NC EDSS or NC COVID.*

5. Communicable Disease Reports – Part 1 and Part 2 communicable disease report forms, morbidity forms, supplemental surveillance forms, and other related records concerning reports of communicable diseases and information on patients' risk factors. Also includes reports of viral hepatitis and sexually transmitted diseases (STDs)/ sexually transmitted infections (STIs). See the following disposition instructions:

   a) Enter required information into the North Carolina Electronic Disease Surveillance System (NC EDSS) or NC COVID. Any documents that are part of the investigation should be attached to the corresponding outbreak event in NC EDSS or NC COVID for retention. NC EDSS and NC COVID records are not scheduled for

expiration or destruction at this time. Paper records may be destroyed once pertinent information is entered into NC EDSS or NC COVID.

b) Destroy records supporting the expenditure of federal funds passed through NC DHHS on a fiscal year basis when the DHHS Office of the Controller provides written guidance that records are released from all audits and other official actions.[1]

c) Destroy in office after 10 years paper records not entered into NC EDSS or NC COVID.*

6. Administrative records shall be kept as long as they are useful to the agency:

- Line listings and general correspondence shall be kept a minimum of one year,
- Administrative documents that are used to establish or interpret policy shall be kept until incorporated into the agency's policy.

7. Manuals shall be retained indefinitely.

8. Records of chemoprophylaxis, vaccination, immunoglobulin, and antitoxin administration shall be kept in accordance with the standards for medical record retention.

* No destruction of records may take place if audits or litigation are pending or reasonably anticipated

[1] See NC DHHS RECORDS SCHEDULE FOR GRANTS, page xi (published semiannually by the DHHS Office of the Controller)

VIII. REFERENCE PLANS AND POLICIES:

Medical Record's Policy, HIPAA, Communicable Disease Program, 24/7 Response for Communicable Disease, Communicable Disease Training and Staff Development, Investigation of Communicable Diseases and Conditions, Surveillance and Reporting of Communicable Diseases, Communicable Disease Risk Communication, and Epidemiology (Epi) Team policies.

NC Communicable Disease Manual/Appendices/Policies & Procedures/Communicable Disease Training &Staff Development, Nov. 2012.

North Carolina Department of Natural and Cultural Resources Division of Archives and Records Government Records Section, *Records Retention and Disposition Schedule Local Health Departments,* March 1, 2019

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: RABIES PREVENTION AND CONTROL

DATE DEVELOPED: 3/15
REVIEWED: 6/15; 6/16; 6/17; 6/18 ; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

All Rockingham County Division of Public Health Services (RCDPHS) staff involved with examination, investigation, and control of rabies follow the guidance published within the North Carolina Rabies Public Health Program Manual located online at: http://epi.publichealth.nc.gov/cd/lhds/manuals/rabies/toc.html. If additional guidance is needed, the agencies will contact the North Carolina Division of Public Health 24/7 on-call epidemiologist at (919) 733-3419.

II. PURPOSE:

Per NCGS 130A-41(b), the Local Health Director is responsible for examination, investigation, and control of rabies. This policy discusses the roles and responsibilities of multiple agency staff. While many functions may be delegated to the Rockingham County Sheriff's Office Animal Control Division, it is essential that human rabies risk assessments be handled by formally trained health care providers.

III. DEFINITIONS:

Per NCAC 130A-184:
http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_130A/GS_130A-184.html.

IV. GUIDELINES:

A. All staff will have access to the North Carolina Rabies Public Health Program Manual. All staff assigned to rabies control will receive rabies related training. RCDPHS will ensure all involved agencies have appropriately trained staff. If a multiple agency training need is identified, RCDPHS will contact NC DPH to assist in in-servicing.

B. There is no written memorandum of agreement (MOA) in place with agencies outside of the LHD who are involved in examination, investigation, and control of rabies. Rockingham County has an animal control ordinance in place which can be found at: https://library.municode.com/nc/rockingham_county/codes/code_of_ordinances?nodeId=PTIICOOR_CH4ANFO.

C. Rabies - Local Roles and Responsibilities

1. County animal control officers are responsible for investigating all incidents involving potential rabies exposures. All investigations will be documented using a standard Incident/Investigation Report.

2. County animal control officers will immediately notify designated RCDPHS rabies staff of all animal bite/non-bite exposures that involve a potential human exposure to rabies by providing a copy of the Incident/Investigation Report to the Environmental Health (EH) Section's rabies on call person from 8:00 a.m. – 5:00 p.m. Monday through Friday at 336-342-8130. After hours and on weekends they should call the County Communications Center at 336-634-3300, and ask the dispatcher to page the Environmental Health Specialist who is on call.

3. The EHS will notify the RCDPHS communicable disease (CD) nurse if there is a potential human exposure and will follow-up on the status of the animal(s) involved in the incident to ensure North Carolina statutes and county ordinances are followed.

4. The CD nurse is responsible for conducting the Human Rabies Exposure Risk Assessment for all human bite exposures. The CD nurse will recommend PEP, if indicated. The CD nurse may assist the exposed person in applying for state indigent funds if needed.

D. Rabies Educational Materials

RCDPHS will provide the following to persons involved in a rabies exposure investigation:

- Animal Bites/Exposures and Rabies Frequently Asked Questions (FAQ)
- Exposure to Rabies: What to Do and Post-Exposure Prophylaxis (Rabies PEP)
- How to Prevent Exposure to Rabies

E. Rabies Pre-exposure Vaccine

1. Routine rabies pre-exposure prophylaxis is not recommended for the general U.S. population. Rabies pre-exposure prophylaxis should be offered to persons who work in occupations where frequent rabies exposure risk has been identified or in travelers who are likely to come into contact with high risk rabies vectors and immediate access to appropriate medical care is limited.

   Refer to the N.C. Rabies Control Manual for additional information, http://epi.publichealth.nc.gov/cd/lhds/manuals/rabies/docs/preEP.pdf .

2. RCDPHS has implemented a standing order to allow a registered nurse (RN) or licensed practical nurse (LPN) to administer the pre-exposure rabies vaccine or booster dose, according to manufacturer's instructions to those persons identified as high risk per the N.C. Rabies Control Manual. See standing order T:\Public Health\RCDPH Standing Orders\ST-I-3 Pre-exposure Rabies.doc.

3. RCDPHS requires payment for vaccines prior to the vaccine being ordered. The process for ordering rabies vaccine is as follows:

   - The requesting agency contacts the Director of Nursing (DON) or Clinical Supervisor (CS).
   - The DON or CS reviews the ordering process, provides the current price and answers any questions the requesting agency may have. The agency is instructed that the person who is to receive the vaccine should come to the health department on each visit with an agency letter signed by the authorizing person.
   - Rabies vaccine is ordered by the accounting clerk in accounts payable through Cardinal Drugs.
   - When the vaccine is received by the health department, the accounting clerk will notify the requesting agency and obtain a list of names of persons to receive the vaccine series, if possible.
   - The accounting clerk will notify a health department immunization nurse or the clinic supervisor to pick up the vaccine or meet them in the pharmacy.
   - The immunization nurse or clinic supervisor will check in the vaccine and verify that the shipping form matches what is in the shipped container. A copy of the form is placed in the vaccine inventory book.
   - The immunization nurse or clinic supervisor will label the rabies vaccine with the agency and/or individuals' name(s).
   - The vaccine is stored in the vaccine refrigerator located in the first floor copy room.
   - The lead immunization nurse or clinic supervisor will enter the inventory in the North Carolina Immunization Registry (NCIR).
   - Once the ordering agency has been notified that the health department has received the rabies vaccine, they will need to
   - Call 342-8141 to schedule an immunization appointment for the employee(s) to receive the vaccine.
   - On each immunization visit, the employee should present to the health department with a letter from their agency that they are to receive rabies pre-exposure vaccine.

- Once the employee has received the rabies vaccine the employing agency may be billed an administration fee by the Data and Processing Billing Department.

4. See the N.C. Rabies Control Manual for description of the rabies pre-exposure regimen at: http://epi.publichealth.nc.gov/cd/lhds/manuals/rabies/docs/preEP.pdf .

F. Rabies Titers

1. Per CDC and ACIP recommendations vaccinated veterinarians, wild life or animal control workers need rabies antibody titers every 2 years; if the titer is less than complete neutralization at a 1:5 serum dilution by the Rapid Fluorescent Focus Inhibition Test (RFFIT), the person should receive a single booster dose of vaccine.

2. The RCDPHS laboratory does not perform rabies titers. However, laboratory staff will collect, prepare and package specimens for shipping. The requesting agency is responsible for (1) payment to the testing laboratory and (2) shipping/shipping charges to the testing facility.

3. For laboratories that perform rabies titers see the N.C. Rabies Control Manual: http://epi.publichealth.nc.gov/cd/lhds/manuals/rabies/docs/preEP.pdf

G. Rabies Post-exposure Human Rabies Immunoglobulin (HRIG) and Vaccine

1. Prompt rabies exposure risk assessment is required for all persons who have been exposed to a potentially rabid animal. Refer to the N.C. Rabies Control Manual for specific guidance; http://epi.publichealth.nc.gov/cd/lhds/manuals/rabies/docs/steps_for HCP.pdf.

2. RCDPHS does not provide rabies post-exposure prophylaxis and/or wound treatment. Persons identified as needing rabies post-exposure prophylaxis and or wound treatment will be instructed to consult their physician or report to the local emergency room of their choice. If possible, the person will be given a Rabies Post-Exposure Prophylaxis Treatment Sheet to give to the treating physician; this sheet can be found at: http://epi.publichealth.nc.gov/cd/lhds/manuals/rabies/docs/ncdhhs_human_PEP_sheet.pdf.

3. Agency staff will be available to consult with exposed persons or physicians during normal working hours and as described in the agency 24/7 policy. RCDPHS will not be responsible for the cost of the HRIG or post exposure rabies vaccine.

4. RCDPHS can follow-up with the administration of subsequent doses of rabies vaccine to indigent persons. See the post-exposure policy: T:\Public Health\RCDPH Policies\Environmental Health\EH-17 rabies post exposure.doc.

5. RCDPHS has implemented a standing order to allow a registered nurse (RN) or licensed practical nurse (LPN) to administer subsequent doses of post-exposure rabies vaccine, according to manufacturer's instructions. See the standing order: T:\Public Health\RCDPH Standing Orders\ST-I-23 Rabies Post-Exposure Prophylaxis.docx .

H. Rabies Human Immunoglobulin and Vaccination Stock

RCDPHS does not stock HRIG or rabies vaccine for post exposure.

I. Vaccine for Indigent Residents

The agency will make every attempt to break down any barrier to access to care. Oftentimes, this relates to an individual not having medical insurance or sufficient resources to pay for rabies prophylaxis. This may be addressed in the following manners:

1. RCDPHS can provide manufacturer contact information. Both manufacturers have indigent resources. This information can be found in the N.C. Rabies Control Manual, http://epi.publichealth.nc.gov/cd/lhds/manuals/rabies/docs/biologics.pdf .

2. The N.C. State Laboratory of Public Health (NC SLPH) maintains stock of both HRIG and rabies vaccine for indigent residents. To obtain this stock the agency must complete the Request for Free State-Supplied Rabies Vaccine form: http://epi.publichealth.nc.gov/cd/rabies/docs/AffidavitFreePEP.pdf .

   - RCDPHS can submit a request for free state-supplied vaccine. Once eligibility and stock requirement is determined the CD nurse will contact the NC DPH Rabies on-call person at (919) 733-3419 and provide the on-call person with the stock requirement, agency shipping address, and point of contact.
   - NC DPH will arrange for shipment from NC SLPH.
   - The Request for Free State-Supplied Rabies Vaccine form should be kept until a bill comes in the mail (the bill does not come with the product). The form should be stapled to the bill and returned to the address on the bill.

3. RCDPHS will reimburse the hospital for stock used. The agency will package and deliver replacement stock to the hospital and make sure patient bill is corrected to not charge for items reimbursed.

J. 10 Day Confinement (for dogs, cats, and ferrets)

The EH rabies on-call person shall contact the animal owner or Animal Control Officer to verify that the biting animal has been confined for 10 days (see the EH-16 Animal Bite Notification policy link below).

- If the biting animal is current on its rabies vaccination, it may be confined at home.
- If the biting animal is not up to date on its rabies vaccination, it must be confined at the Rockingham County Animal Shelter or another health director approved facility.

See T:\Public Health\RCDPH Policies\Environmental Health\EH-16 animal bite notification.doc.

K. Specimen Submittal for Rabies Testing/Weekend and Holiday Testing

General specimen submittal guidelines can be found in the N.C. Rabies Control Manual at: http://epi.publichealth.nc.gov/cd/lhds/manuals/rabies/testing.html.

For specimen handling see policy EH-17 T:\Public Health\RCDPH Policies\Environmental Health\EH-17 rabies post exposure.doc.

NC SLPH does not perform testing on weekends and holidays unless approval has been given by DPH. Call DPH rabies on-call staff at (919) 733-3419 to discuss need for weekend or holiday testing. If approved, the outside of the package being delivered to NC SLPH should have a highlighted statement "For Weekend Testing" put on the package. The DPH on-call staff should be told the persons exposed as well as the name and number of the person receiving the results for the county. It is policy that NC SLPH/DPH verbally gives the results to appropriate county staff.

L. Notification to Outside Agencies

RCDPHS will ensure that all appropriate agencies are informed of potential rabies exposures.

- N.C. DA&CD Veterinary Division (www.ncagr.gov/vet) is responsible for rabies following up and conduction field investigations of any equine or livestock exposures. The main number is (919) 733-7601.
- Multiple agencies could be involved in rabies investigations regarding hybrid or exotic animals. Contact DPH rabies on-call person at (919) 733-3419 to discuss any investigation containing livestock, hybrid, or exotic animals.

M. Resident Request to Appeal Rabies Decisions

See the Rockingham County Animal Control ordinance at: http://www.co.rockingham.nc.us/files/documents/Animal_Control_Ordinance_02-23-2011_111123.pdf.

N. Rabies Clinics and Certified Rabies Vaccinators

The Environmental Health Section will annually assist with the Rockingham County Animal Shelter's rabies vaccination clinics as required by G.S. 130A-187. Clinics will be advertised to inform the public of times and locations for maximum citizen involvement. Vaccinators will be licensed veterinarians or CRVs from the County Animal Shelter. The public will be reminded that all dogs, cats and ferrets more than four months old must be vaccinated against the rabies virus, as required by law.

O. Community Outreach

An annual reminder is sent out by blast fax, email or mail to the hospitals, physicians, veterinarians, sheriff's office and emergency management regarding reporting requirements and 24/7 contact information for environmental health and communicable disease staff.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: HEPATITIS B PROTOCOLS

DATED DEVELOPED: 4/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/20

I. POLICY:

The Division of Public Health Services (RCDPHS) will follow the guidance within the North Carolina Hepatitis B Public Health Program Manual (February 2012) located online at http://epi.publichealth.nc.gov/cd/lhds/manuals/hepB/toc.html. If additional guidance is needed, the agencies will contact the North Carolina Division of Public Health 24/7 on-call epidemiologist at (919) 733-3419.

II. PURPOSE:

The Division of Public Health Services staff will educate clients in all clinical settings, especially STD and Women's Preventive Health, about Hepatitis B infection and modes of transmission. The main focus is to prevent transmission of hepatitis B infection through pre-exposure vaccination. All clients seeking STD screening or treatment for a STD should be considered as candidates for hepatitis B vaccinations per North Carolina Immunization Program (NCIP) guidelines.

III. GUIDELINES:

A. Incubation period: 45-160 days, with the average being 60-90 days.

B. Transmission:

1. Parenteral, including tattoos, body piercing, and acupuncture, if equipment is infected
2. Sexual and perinatal
3. Sharing of personal hygiene items, which may contain blood from the infected person, (i.e. toothbrushes, razors).
4. Work exposures for health care workers, (needle-stick injuries, exposure to open wounds on the skin, or eye splashes) with blood or bodily fluids from an infected client.

C. Groups at high risk for Hepatitis B Virus Infection:

1. Heterosexual persons who have had more than one sex partner in the previous 6 months and/or those with a recent episode of a sexually transmitted disease.

2. Sexually active homosexual or bisexual males.

3. Household contacts and sex partners of Hepatitis B surface antigen (HbsAg) positive persons.

4. Injection drug users.

5. Health care workers and others at occupational risk.

6. Clients and staff of institutions for the developmentally disabled, including nonresidential day-care programs if attended by known HBV carriers.

7. Hemodialysis patients.

8. Hemophiliacs and other recipients of certain blood products.

9. Household contacts of adoptees from HBV-endemic, high-risk countries who are HbsAg-positive.

10. International travelers who spend more than 6 months in areas where HBV infection rates are high and who have close contact with the local population; also short-term travelers who have contact with blood or sexual contact with residents in high or intermediate risk areas.

11. Inmates of long-term correctional institutions.

12. Infants born to infected mothers.

13. Persons born in areas where HBV is endemic.

D. Testing:

1. Screening and testing is done on clients as symptoms or history indicates; refer to DHHS Form 3722; Laboratory for Hepatitis Serology testing data.

2. Contacts to Hepatitis B are screened and tested according to the State Laboratory Guidelines (see #1 above); also, the Division of Health and Human Services' laboratory has complete policies and procedures on all testing that is initiated or completed for its clients.

3. HBsAg screening is done 6 months after an acute case; if remains positive, re-test in another 6 months. Two documented positive HbsAg results, six months apart constitutes diagnosis for a carrier.

E. Prevention: Counseling is vital to the prevention of the spread of Hepatitis B. This is done in the STD clinic as part of the routine STD counseling by the clinic staff.

1. HBIG is available for sexual contacts, needle sharing partners, and babies born to infected mothers. It is standard medical practice for all newborns to receive the first Hepatitis B vaccination prior to being discharged from the hospital.

2. Acute: Hepatitis B vaccine to sexual contact, needle-sharing partners, and household contacts of children under the age of 12 months, with baby having been born to an infected mother in the event that the baby has not been immunized, as scheduled by the state since birth.

3. Carrier: Household contacts, baby born to infected mother, sexual and needle-sharing partner(s).

4. Limit number of sexual partners; use latex condoms for all sexual activity.

5. Do not share personal items such as razors, toothbrushes, etc.

6. Before having tattoos, body piercing and acupuncture, inquire how equipment has been cleaned and sterilized.

F. Follow-up to reported case of Hepatitis B: The Division of Public Health Services' Communicable Disease Coordinator completes follow-up and investigation of all reported cases of Hepatitis B for Rockingham County residents which may include the following:

1. Contact attending physician for information regarding laboratory results, symptoms, duration of illness, and any information needed for investigation. All HIPAA guidelines are followed in obtaining all of this information.

2. Contact infected client, initiate Hepatitis B surveillance form which may be acute or chronic (carrier).

3. Counsel contacts on need for HBIG and Hepatitis B vaccination series; provide information regarding where HBIG and Hepatitis B vaccinations are given; refer clients to a private medical care provider.

   HBIG needs to be given as soon as possible after exposure:

   a. Sexual exposure within 14 days (0.06ml/kg)
   b. Percutaneous or mucous membrane within 24 hours (0.06ml/kg)
   c. Infants born to HbsAg positive mothers should be given a single dose of HBIG 0.5 ml IM within 12 hours after delivery.

d. Hepatitis B vaccine should be given at same time as HBIG and continued at one month (after first dose) and five months (after second dose)

4. Provide education on disease, its mode of transmission, and prevention of spread to other persons.

5. Screening and testing is done according to State Laboratory Guidelines (see the Division of Public Health Services' Laboratory Guidelines and Protocols).

G. Hepatitis B vaccination dosages and schedules:

1. For children and adolescents up to age 18 years: 0.5 cc IM, in three doses (initial dose at birth, second dose one to two months after first dose, third dose 6-18 months of age).

2. For persons >18 years and above, 1.00 cc IM, in three doses (initial dose, second dose one month after first dose, third dose five months after second dose).

3. Combination Hepatitis A/B vaccine may be available per current NCIP guidelines and client eligibility.

H. Record Retention and disposition schedule:

1. *Perinatal Hepatitis B Prevention Report Part I* records - tracking the testing and vaccination status of newborns exposed to Hepatitis B at birth.

a. Enter required information into the North Carolina Electronic Disease Surveillance System (NC EDSS) and the North Carolina Immunization Registry (NCIR).
b. Destroy in office when individual reaches 30 years of age and has not received services within the last 10 years.*

2. *Perinatal Hepatitis B Prevention Report Part II* records - tracking the testing and vaccination status of contacts of pregnant females who have Hepatitis B.

a. Enter required information into the North Carolina Electronic Disease Surveillance System (NC EDSS) and the North Carolina Immunization Registry (NCIR).
b. Destroy in office 10 years from date of last service.

* No destruction of records may take place if audits or litigation are pending or reasonably anticipated.

IV. REFERENCE PLANS AND POLICIES:

NC Communicable Disease Manual Nov. 2012.

North Carolina Hepatitis B Public Health Program Manual (February 2012) located online at http://epi.publichealth.nc.gov/cd/lhds/manuals/hepB/toc.html.

North Carolina Department of Natural and Cultural Resources Division of Archives and Records Government Records Section, *Records Retention and Disposition Schedule Local Health Departments,* March 1, 2019 (pg.37)

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: REFERRAL OF EMPLOYEE, POTENTIAL EMPLOYEES, AND IMMIGRATION APPLICANTS WITH POSITIVE MANTOUX SKIN TESTS (TSTS) OR INTERFERON GAMMA RELEASE ASSAYS (IGRA)

DATE DEVELOPED: **10/03**
REVIEWED: **6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/17; 6/18; 6/22**

I. POLICY:

The Division of Public Health Services will implement a referral policy for persons with a positive Mantoux skin test (TST) or interferon gamma release assay (IGRA) seeking employment or citizenship that complies with the current North Carolina Tuberculosis Policy Manual and reflects the Immigration and Naturalization Service Requirements. The Division of Public Health Services' North Carolina Tuberculosis Nurse Consultant, Tuberculosis Medical Consultant, and the Medical Director have reviewed this policy.

II. PURPOSE:

To provide referring physicians, local hospitals, Division of Public Health Services staff, occupational health services, and employers the criteria for referral of employees, potential employees, and immigration applicants with positive Mantoux skin tests (TSTs) or IGRA to the Division of Public Health for evaluation and treatment of latent tuberculosis infection (LTBI).

III. GUIDELINES:

A. Routine testing of low risk individuals is not recommended per the North Carolina TB Policy Manual.

B. The Mantoux tuberculin skin test is the only skin test recommended for latent TB screening by NC TB Control.

C. Candidates for TST

- TST of individuals and groups should be undertaken only if the diagnostic evaluation and a course of preventive therapy can be completed.
- Routine testing of low-risk individuals is not recommended; locally purchased PPD must be used for all low-risk testing, e.g., job-related.
- State supplied PPD may be used only for persons in categories #1-7 below due to the high risk for infection or disease.

1. The following children and adults are legally required by law (10A NCAC 41A.0205) to receive a TST or IGRA:

   a. household and other close contacts of active cases of pulmonary and laryngeal tuberculosis (at the time of exposure and 3 months post exposure).
   b. persons reasonably suspected of having tuberculosis disease
   c. inmates in the custody of the Department of Corrections upon incarceration or employment and annually
   d. Department of Corrections employees with direct inmate contact upon employment
   e. patients and employees in long term care facilities upon admission and employment, using the two-step for TST or an IGRA. DFS regulations require an annual screening which can be accomplished by a verbal elicitation of symptoms
   f. employees in adult day care centers providing care for persons with HIV infection or AIDS upon employment, using the two-step TST or an IGRA
   g. persons with HIV infection or AIDS when diagnosed with HIV

2. The following children and adults should receive a <u>baseline</u> TST or IGRA when they initially present for health care:

   a. foreign-born individuals from high incidence areas such as, Asia, Africa, Caribbean, Latin America, Mexico, South America, Pacific Islands or Eastern Europe

      <u>Low-prevalence countries for TB disease are USA, Canada, Japan, Australia, Western Europe and New Zealand</u>

   b. individuals who inject illicit drugs or use crack cocaine
   c. migrants, seasonal farm workers, and the homeless (if unable to ensure completion of evaluation and TLTBI, screen for disease)
   d. persons who have traveled outside the US and stayed with family and/or friends who live in high incidence areas for greater than one month cumulatively
   e. children and adolescents exposed to high-risk adults (homeless, substance abuse, incarcerated, HIV positive)
   f. persons with conditions that increase the risk of progression to disease once infected
      - diabetes mellitus
      - chronic renal failure
      - chronic malabsorption syndrome

- leukemia, lymphomas, Hodgkin's disease
- cancer of the head or neck
- silicosis
- weight loss of > 10% ideal body weight
- gastrectomy or intestinal bypass

A subsequent TST is not necessary unless there is a continuing risk of exposure to persons with tuberculosis disease.

3. Persons taking or considering taking tumor necrosis factor (TNF) inhibitors (e.g., etanercept, infliximab, adalimumab or anakinra) which can suppress the immune system are at high risk for TB disease if infected. Before starting these drugs, an IGRA or TST should be done (preferably a 2-step TST test) and treatment for LTBI started if the reading is 5 mm or greater. If there is a credible history of exposure to TB, TLTBI should be initiated regardless of TST result.

4. Clinically assess all household members in the immediate environment of a child ≤ 2 years of age with a newly identified positive TST or IGRA to rule out an undiagnosed case of tuberculosis. An assessment should include an evaluation of symptoms for TB disease and may include a TST or IGRA, bacteriological examination and chest x-ray, if indicated.

5. Clinically assess all household members in the immediate environment of a pregnant woman with a newly identified positive TST to rule out TB exposure in the immediate environment that the newborn infant will be entering. An assessment should include an evaluation of symptoms for TB disease and may include a TST or IGRA, bacteriological examination and chest x-ray, if indicated.

6. Homeless Shelters

   a. Staff and volunteers should be educated regarding the symptoms of tuberculosis disease. Those clients with symptoms suggesting TB disease should be promptly evaluated for active disease.
   b. Staff and volunteers should receive a two-step TST or IGRA on employment.
   c. Routine TST or IGRA of clients should be undertaken only if the diagnostic evaluation and course of preventive therapy can be initiated and completed.

7. Local Jails and Detox Units

   a. All jail facilities must conduct a facility specific risk assessment. For additional guidance, see Prevention and

Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC MMWR 2006; 55 (No RR-9).

b. Test staff with a TST (upon employment) using the two-step method or IGRA. Annual TST or IGRA is based on the facility's current risk level.

c. Verbally screen all inmates for symptoms of TB on admission. Inmates with symptoms suggesting TB disease should be evaluated for active disease.

8. For staff and residents in occupational settings where TST is required by regulatory (OSHA) and/or agency policy, but not law. State supplied PPD is not used.

Use private purchased PPD for the following:

- Employees of hospitals, EMS, laboratories, ambulatory facilities, hospice, home health, dental health, homeless shelters, drug treatment centers, child day cares, subsidized non-licensed child care homes, family care homes, adult assisted living, rest homes, group homes, health check participants, foster families, and for college admissions.
- Medial offices or settings that do not fall into one of the above categories should conduct periodic risk assessments and testing of employees should be based risk and the likelihood of providing care to persons with TB disease.

a. A two-step TST (upon admission or employment) individuals who cannot provide a documented negative TST within the preceding 12 months:

- Individuals who can provide a documented negative TST within the preceding 12 months should receive a single TST and use this result as the second part of the two-step test
- Individuals who can provide a documented positive TST should have a Record of Tuberculosis Screening (DHHS 3405) completed using the most recent chest x-ray report.

b. Individuals with a previously documented positive TST should be re-x-rayed only when symptoms of tuberculosis disease are present.

9. Notification of Arrival of Class A and B Immigrants and Refugees

a. After the health department receives state notification that an immigrant or refugee with a class A or B condition has arrived, they should contact the patient to begin an evaluation to rule out active and latent tuberculosis and to treat these conditions if they are identified.

b. The immigrant/refugee is instructed while overseas to present to their local health department for evaluation. When the patient comes in for the medical evaluation, complete the TB Epidemiological Record (DHHS 1030). Enter the date first seen in the US for TB evaluation.

c. TB Agreement addenda objectives require that the medical evaluation begin within 30 days of arrival and that the entire evaluation be completed within 90 days.

d. Basic testing is done prior to the immigrant/refugee arriving. Prior to entering this country, federal regulations require newly arrived refugees $\geq$ 15 years of age (Southeast Asians $\geq$ 2 years of age are required to have a chest x-ray) to have a medical exam consisting of a chest x-ray. Sputum smears are only done if the chest x-ray indicates possible TB disease. Overseas exams do not include a TST or sputum for culture. The required chest x-ray may have been done up to 2 years prior to arrival in the US.

e. The immigrant/refugee should have a copy of their digital chest x-ray. If you have access to a copy of the chest x-ray, it would be ideal to have your local physician or radiologist review it when possible. Repeat chest x-ray if the original is of poor quality or x-ray is > 6 months old.

f. If no TST or IGRA results are available, a TST or IGRA should be obtained.

g. Sputum for AFB smear and culture and a new chest x-ray should be obtained if the patient is symptomatic for TB.

h. When TB disease is ruled out, consider treating for LTBI if indicated.

i. Repeat screening is not necessary in asymptomatic individuals.

j. Refugees arriving in this country without an A or B classification status (normal chest film) who are determined to have a positive PPD during their initial evaluation should have a new chest film taken before starting treatment for LTBI.

D. Chest X-rays

1. A posterior-anterior view of the chest should be obtained on all adults:

   a. with a newly identified positive TST or IGRA
   b. with symptoms suggestive of TB disease regardless of TST/IGRA results
   c. with suspected extrapulmonary TB disease
   d. with negative TST/IGRA and starting treatment for LTBI, i.e., close contact

2. A posterior-anterior and lateral view of the chest should be obtained on children under 5 years of age:

   a. with a newly identified positive TST or IGRA
   b. with symptoms suggestive of TB disease regardless of TST/IGRA results
   c. with suspected extrapulmonary TB disease
   d. with negative TST/IGRA and starting latent TB treatment, i.e., close contact

3. Due to risk of progressive and/or congenital TB, pregnant women should have a PA view of the chest (with appropriate shielding) as soon as possible, even during the first trimester of pregnancy, if they have a positive TST or IGRA.

4. Individuals with a previous documented positive TST or IGRA and a negative chest x-ray should repeat x-ray only when symptoms of TB are present (see Chapter III of the NC TB Control Manual).

E. Fees may be charged by the Division for TSTs and/or TB screening not related to epidemiological TB treatment or follow-up.

IV. REFERRAL CRITERIA:

A. Immigration: The INS (Immigration and Naturalization Service) requirements state that the designated civil surgeon is responsible for the entire medical examination and required tests. The fees for these services are paid to the INS designated physician by the individual going through the immigration procedure. It is not the responsibility of the local health department to provide these services for the follow-up on their clients. The Division of Public Health Services will provide treatment/or follow-up for tuberculosis disease cases and clients willing to take preventive treatment for a standard regimen as indicated in the current NC TB Control Program Policy Manual located at http://epi.publichealth.nc.gov/cd/lhds/manuals/tb/toc.html after the required tests are completed (TST and chest x-ray).

B. Employment: The Division of Public Health Services is not required to pay for/provide TSTs or IGRAs for employment purposes. If TST is planted by the Division and is positive, the employee will be sent to UNC Rockingham Health Care for a chest x-ray and the cost of the chest x-ray and interpretation will be paid by the Division of Public Health Services at a contracted rate.

The Division of Public Health Services is required to provide TSTs or chest x-rays for epidemiological TB treatment and follow-up to cases of TB along with those required by General Statutes (as stated in III-C above).

1. Employee or potential employee may have both of the following performed prior to referral:

    a. Mantoux skin test (TST) placed and read between 48-72 hours later (72 hours is the recommended time, induration not redness should be read east to west and recorded in one measurement only).
    b. Chest radiograph within one month of (TST) Mantoux skin testing.

2. Employees or potential employees may be referred in the following circumstances:

    a. Positive IGRA or Mantoux skin test with negative chest radiograph and employee is willing to take TB prophylaxis.
    b. Positive IGRA or Mantoux skin test with symptoms suggestive of Tuberculosis (such as fever, night sweats, productive cough >3 weeks, weight loss, chest pain, shortness of breath, and fatigue) and/or abnormal chest radiograph. The Division of Public Health Services' Communicable Disease Nurse should be called and arrangements made before having client report to the Division.
    c. Equivocal Mantoux skin test result (for "second opinion" on Mantoux test result), the person should report to the Division of Public Health Services that same day. The person would then be referred back to the provider for an order for a chest x-ray and then referred to the Division as stated above.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TB MEDICAL SERVICES

DATE DEVELOPED: 4/14
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/22

I. POLICY:

The goal of the North Carolina Tuberculosis (TB) Program is to eliminate tuberculosis disease. To help achieve this goal, The Division of Public Health Services (DPHS) will focus on:

- reducing the number of new cases of TB
- controlling the spread of TB in the community
- providing proper TB case management
- contracting with a physician who has expertise in treating tuberculosis, including multi drug resistant TB.

II. PURPOSE:

To manage clients with TB disease or infection in accordance with current North Carolina TB Program policies and procedures in the *NC Tuberculosis Policy Manual* found at: *http://epi.publichealth.ncgov/cd/lhds/manuals/tb/toc.html.*

III. DEFINITIONS:

1. TB – Tuberculosis

2. LTBI - Latent Tuberculosis Infection

3. NC EDSS - North Carolina Electronic Disease Surveillance System

IV. APPLICABLE LAW, RULES AND REFERENCES:

The standard of care for TB services is based upon:

- The North Carolina TB Control Policy Manual located at**:** http://epi.publichealth.nc.gov/cd/lhds/manuals/tb/toc.html.
- 10A NCAC 41A.0205 - Control Measures- Tuberculosis

V. RESPONSIBLE PERSON(S):

The Division of Public Health Services Health Director is responsible for assuring compliance with the Agreement Addendum. The Communicable Disease Control Coordinator has the delegated oversight program responsibility. The TB Medical Consultant assures that TB clients are managed in accordance with North Carolina TB Program policies and procedures.

VI. PROCEDURES:

A. To be in compliance with the scope of work and deliverables of the Agreement Addendum 554 (TB Medical Services), DPHS shall assure the following:

1. Annually review and renew contract with a physician as the TB Medical Director who is capable of providing and maintain medically appropriate care for TB clients.

2. Provide TB medical services to temporary or permanent residents of Rockingham County. Medical services may be delivered through the health department or by private practitioners through a variety of approaches including, but not limited to office or clinic visit, telephone consultations, faxes, emails, or telemedicine services.

3. Provide TB medical services that are consistent with:

   a. Acceptable medical practice consistent with North Carolina Medical Board policies and standards.
   b. North Carolina TB Control policies contained in the TB Manual and the recommendations found in the American Thoracic Society's *Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children.*

   (http://www.thoracic.org/statements/resources/mtpi/tbchild1-16.pdf)

4. Ensure the contracted physician agrees to:

   a. Consult with other community physicians who request consultation.
   b. Counsel physicians who prescribe outside the treatment protocols recommended by the North Carolina TB Program.
   c. Document participation in at least one TB related medical education event annually.
   d. Meet and consult with the North Carolina TB Medical Director, TB Nurse Consultant, designated Infectious Disease Physicians or TB Medical Advisory Committee members as deemed appropriate and necessary.

5. Ensure all standing orders or protocols developed for nurses in support of this program are written in the North Carolina Board of Nursing format. Have a policy in place that supports nurses working under standing orders. https://www.ncbon.com/vdownloads/position-statements decision-trees/standing-orders.pdf

B. DPHS will ensure that the contracted physician will, at a minimum

1. Treat and monitor all active TB cases according to the policies and procedures in the North Carolina TB Manual such that:

   a. All orders for treatment will be signed and dated
   b. Clients will have a documented visit with the physician or other designated provider on at least two occasions: once at the beginning of treatment and once at the end. If the client has another provider a visit from this provider may substitute for the visit with the contracted health department physician.

2. Treat and monitor all clients with latent TB according to the policies and procedures in the North Carolina TB Manual.

3. Participate in the annual Cohort Review to review management of active cases during the previous year with North Carolina TB Control staff if active cases meet TB cohort review criteria.

4. Attend at least one TB-related continuing medical education activity per year and inform the TB nurse the education was obtained. This information will be shared with the TB Nurse Consultant.

C. Performance Monitoring and Quality Assurance:

1. The State TB Medical Director and other infectious disease (ID) medical faculty who are TB experts at Duke Medical Center are available to provide medical consultation as needed in North Carolina. Pediatric TB consultative expertise is available through Carolinas Medical Center.

2. Annual assessments are conducted by the Regional TB Nurse Consultants. The review process covers TB case management, contact investigations, targeted testing data, and completion of treatment of latent TB infection data from the previous year and status review of the current TB caseload.

3. TB case reports are entered into North Carolina Electronic Disease Surveillance System (NC EDSS). Results and findings of individual county assessments are communicated to the county health directors

and local TB program staff in the assessment reports. Program successes, deficiencies, and corrective action plans (when necessary) are key components of this report.

4. In addition to the annual assessment, evaluation and management of all active TB cases will be reviewed during the formal annual cohort review. An evaluation letter will be generated from the cohort review, and may include a corrective action plan.

5. Failure to address issues raised in a corrective action plan may be cause for reduction or loss of funding.

6. The contract with individual physicians will be reviewed and renewed annually.

7. By June 30, 2022, the Health Director shall provide the DPH Program Contact with the contracted TB Clinician's name, addresses (physical, mailing, and email), phone numbers (office and mobile), and fax number. If there is a designation change in TB Clinician during the Agreement Addendum's Service Period, the Health Director shall provide this same information about the newly designated TB Clinician to the DPH Program Contact within 30 days of the change.

8. The TB Clinician has consultative back-up available which is provided 24 hours a day, 7 days a week, through a contract between North Carolina TB Control Program and Duke University. Dr. Jason Stout at Duke University is the current North Carolina TB Medical Director/TB Controller.

VII. REFERENCE PLANS and POLICIES:

NC Tuberculosis Control Policy Manual/Appendices/Policies and Procedures.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TB CONTROL

DATE DEVELOPED: 4/2014
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/20; 6/22

I. POLICY:

The health department has the legal authority and responsibility to coordinate all tuberculosis (TB) efforts in Rockingham County. To achieve the goal of TB elimination, the Division of Public Health Services will focus on:

- reducing the number of new cases of TB
- controlling the spread of TB in the community
- providing proper TB disease case management
- provide preventive treatment to those with latent TB infection (LTBI)
- contracting with a physician who has expertise in treating tuberculosis, including multi drug resistant TB.

II. PURPOSE:

To manage clients with TB disease or infection in accordance with North Carolina TB Program policies and procedures in the *NC Tuberculosis Policy Manual* found at: *http://epi.publichealth.ncgov/cd/lhds/manuals/tb/toc.html.*

III. DEFINITIONS:

1. TB = tuberculosis
2. LTBI = latent tuberculosis infection
3. NC EDSS = North Carolina Electronic Disease Surveillance System

IV. APPLICABLE LAW, RULES AND REFERENCES:

The standard of care for TB services is based upon:

- The North Carolina TB Control Policy Manual (January 2015).
- 10A NCAC 41A.0205 - Control Measures- Tuberculosis

V. RESPONSIBLE PERSON(S):

Within the Division of Public Health Services, the Communicable Disease Control Coordinator has the delegated oversight TB program responsibility. The TB Medical Consultant assures that TB clients are managed in accordance with North Carolina TB Program policies and procedures.

VI. GUIDEANCE:

A. To be in compliance with the scope of work and deliverables of the Agreement Addendum 551 (TB Control), the Division of Public Health Services shall meet the following performance measures as required by the Centers for Disease Control (CDC).

1. Have at least one TB nurse assigned to TB prevention and control activities.

2. Provide individual programmatic interventions for all new TB cases.

3. Work to increase rates of completion of therapy for TB and LTBI.

4. Work to improve timely completion of therapy

5. Have a local clinician as TB Medical Director to provide TB medical services. The NC TB Control Program provides a 24/7 TB medical consultant to assist local clinicians as needed.

6. All TB cases, contacts and persons receiving LTBI will be reported in the North Carolina Electronic Disease Surveillance System (NC EDSS).

7. DPHS has the legal authority and the responsibility to coordinate and aggressively interrupt TB transmission through appropriate disease treatment regimens and minimize the number of people who become newly infected with TB, and to provide appropriate preventive treatment to those already infected.

B. The Division of Public Health Services will strive to meet the required annual assessment percentages as stated in Agreement Addendum 551 by completing the following:

1. TB cases with initial positive sputum cultures will have documentation of culture status every 2 weeks until microbiologic conversion to negative is achieved.

2. TB cases with positive sputum culture results will have documented conversion to sputum culture-negative within 60 days.

3. TB cases with positive AFB sputum-smear results will have treatment initiated within 7 days of specimen collection.

4. Clients who are suspected of having TB will be started on the recommended initial 4-drug regimen and that information will be entered into NC EDSS.

5. TB cases will receive directly observed therapy (DOT) in accordance with North Carolina TB Control policy and state law for the duration of treatment in North Carolina and that information will be entered into NC EDSS.

6. Clients with newly diagnosed TB and for whom 12 months or less of therapy is indicated will complete treatment within 12 months and that information will be entered into NC EDSS.

7. Contact information for pulmonary and pleural cases will be completely entered in NC EDSS by completing the contact summary wizard.

8. TB clients with positive AFB sputum–smear results will have contacts identified and entered into NC EDSS.

9. Contacts to sputum AFB smear-positive TB cases will be fully evaluated and that information will be entered into NC EDSS.

10. Contacts to sputum AFB smear-positive TB cases with newly diagnosed latent TB infection (LTBI) will start treatment and that information will be entered into NC EDSS.

11. Contacts to sputum AFB smear-positive TB cases, who start treatment for newly diagnosed LTBI, will complete prescribed treatment and that information will be entered into NC EDSS.

12. Persons (non-contacts) who begin treatment for latent infection will complete treatment.

13. All TB cases alive at diagnosis will have HIV test results recorded in their medical record and in NC EDSS.

14. All suspect TB cases will be reported in NC EDSS to the regional TB Nurse Consultant within 7 days of notification.

15. Surveillance reports (Report of Verified Case of Tuberculosis plus the Follow Up #1 Report) on both laboratory and clinically confirmed cases will be forwarded electronically to the nurse consultant within 12 weeks of starting treatment.

16. Report of Verified Case of Tuberculosis (RVCT) data items will be reported electronically in NC Electronic Disease Surveillance System.

17. Follow Up #2 Reports will be reported through NC EDSS to the nurse consultant within 4 weeks of treatment completion.

18. The Public Health Nurse who is responsible for the TB Control program will have attended the *Introduction to Tuberculosis Management* course or will attend the next date the course is offered. The TB nurse will complete the NC EDSS training class within four months of starting the TB Nurse role.

19. TB case medical records will, at a minimum, contain the following:

    a. Signed and dated physician orders for the treatment of disease and consistent with the NC TB Control Manual Policies
    b. Monthly documentation of assessment for possible medication side effects
    c. TB Epidemiological Record completed
    d. Interpretation of the initial chest x-ray (report)
    e. Signed TB treatment agreement or isolation order
    f. Baseline lab results and subsequent lab results as indicated
    g. TB Drug Record/DOT record containing current and accurate information
    h. End of treatment chest x-ray, if a pulmonary or pleural case
    i. Documented visit with a healthcare provider at the beginning and end of therapy

20. Class B immigrants and refugees will have a medical evaluation initiated within 30 days of arrival.

21. Class B immigrants and refugees will have a completed medical evaluation and presumptive diagnosis within 120 days of arrival.

22. Class B immigrants and refugees who are diagnosed with latent TB infection (LTBI) during evaluation in the U.S. will complete treatment.

23. Class B events in NC Electronic Disease Surveillance System (NC EDSS) will have all core data items completed.

24. TB cases with a pleural or respiratory site of diseases and who are 12 years or older will have a sputum-culture result reported.

C. Reporting Requirements via Smartsheet

Complete the following reports via the Smartsheet dashboard, which can be accessed at https://app.smartsheet.com/b/publish?EQBCT=82018408e7b44ef9b44113b6e536ffb. All of the due dates for these reports are posted on the Smartsheet dashboard.

1. Monthly Financial Reports: Will report on the prior month. The first financial report is for June 2022 and is due by July 22, 2022.

2. Quarterly Performance Reports: These quarterly reports will detail the prior period's progress on implementing the Agreement Addendum and shall include the county's number of current active cases and contacts, how many LTBI cases initiated medication, how many LTBI completed medication, and when having provided DOT and DOPT, how many are provided face-to-face and how many are provided electronically. The first report is to report for June, July, and August 2022 activities and is due by September 22, 2022. The periods for these reports are defined as:

    - June – August 2022
    - September – November 2022
    - December 2022 – February 2023
    - March – May 2023

D. Performance Monitoring and Quality Assurance:

1. Annual assessments are conducted either on-site or by phone (if the county had no cases for the year) by the Regional TB Nurse Consultants. The review process covers TB case management, contact investigations, targeted testing data, and completion of treatment of latent TB infection data from the previous year and status review of the current TB caseload.

2. TB case reports are entered into North Carolina Electronic Disease Surveillance System (NC EDSS). Results and findings of individual county assessments are communicated to the county health directors and local TB program staff in the assessment reports. Program successes, deficiencies, and corrective action plans (when necessary) are key components of this report.

3. Failure to comply with issues raised in a corrective action plan related to the most recent monitoring site visit may be result in reduction or loss of funding.

D. TB Records Retention and Disposition Schedule:

<u>Tuberculosis (Clinical) Records</u> - clinical records for patients with tuberculosis (TB). File also includes summaries of treatment, x-rays, culture results, drug records, counseling, and other related records.

1. Negative test: Destroy in office after 1 year.

2. TB infection (no disease): Retain interpretation of most recent x-ray films, TB drug record if treated, and HIV test results if tested for life of patient. Destroy x-ray films 10 years from date of last service.

3. TB disease: Retain summary of treatment, most recent x-ray films including interpretations, TB drug record, HIV test results if tested, most recent mycobacterium TB culture result with susceptibilities, and hospital discharge summaries, if any, for life of patient. Destroy all but the most recent x-ray films 10 years from date of last service.

4. When patient reaches 90 years of age or is deceased: Destroy records and x-ray films 10 years from date of last service.

VII. REFERENCE PLANS and POLICIES:

NC Tuberculosis Control Policy Manual/Appendices/Policies and Procedures.

North Carolina Department of Natural and Cultural Resources Division of Archives and Records Government Records Section, *Records Retention and Disposition Schedule Local Health Departments,* March 1, 2019, (pg. 38)

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: VIDEO OF DIRECTLY OBSERVED THERAPY

DATE DEVELOPED: 3/2015
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The health department has the legal authority and responsibility to coordinate all tuberculosis (TB) efforts in Rockingham County. To achieve the goal of TB elimination, the Division of Public Health Services may:

1. Use video Directly Observed Therapy (DOT) to supervise ingestion of medications for selected clients with active or latent tuberculosis who meet the inclusion criteria listed below.

2. For TB control/program purposes, use video DOT. Video DOT is considered equivalent to in-person directly observed therapy.

3. Use video DOT to monitor client adherence. If any concerns arise there should be a low threshold to resume conventional directly observed therapy.

4. Not substitute video DOT for monthly in-person monitoring visits.

II. PURPOSE:

To provide guidelines for the use of video directly observed therapy (video DOT) by public health providers in North Carolina. Video DOT is defined as the use of remote video (e.g. streaming video using a service such as Skype or Facetime) by a healthcare provider to observe a client ingesting medications.

III. RESPONSIBLE PERSON(S):

Within the Division of Public Health Services, the Communicable Disease Control Coordinator has the delegated oversight TB program responsibility. The TB Medical Consultant assures that TB clients are managed in accordance with North Carolina TB Program policies and procedures.

IV. PROCEDURES:

A. Administrative Requirements

The following three administrative requirements must be met prior to initiation of video DOT:

1. Signed order by the attending public health/tuberculosis physician.
2. Signed treatment agreement by the client.
3. Approval by the regional nurse consultant.

B. Technological Requirements

1. Client must have a working mobile phone with videophone (e.g., Facetime) capability that can interface with corresponding technology at the local health department OR
2. Client must have a working computer with broadband internet connectivity and a webcam capable of transmitting sound and video.

C. Client Selection

Video DOT may be offered to adult (18 and over) clients with active TB that meet the following criteria:

1. Good response to treatment as judged by the treating clinician. Examples of a good response would be decreasing degree of sputum smear positivity and/or improved signs and symptoms.
2. Motivated to complete treatment with psychosocial support to attain this goal.
3. No prior problems with missed DOT doses, missed appointments, or non-adherence.
4. Client has demonstrated successful swallowing of all pills within a five-minute period.
5. No treatment interruptions due to medication toxicity or intolerance.
6. Stable residence and living conditions.
7. Able to communicate directly with TB program staff using appropriate language skills.
8. Client must be able to clearly identify by name and quantity each drug as it is ingested while provider maintains a clear view of the client's face and mouth.
9. There is no known resistance to any of the first-line anti-tuberculosis drugs (isoniazid, rifampin, pyrazinamide, or ethambutol). If drug

resistance is identified the state nurse consultant should be contacted regarding whether continued video DOT is appropriate.

10. In-person DOT is strongly recommended for at least the first 14 doses of treatment for most clients with pulmonary TB, particularly smear-positive TB.

Clients with latent TB may be offered video DOT at the start of latent TB treatment at the discretion of the client and treating clinician.

D. Video DOT Procedure

1. Client and public health provider will establish a standing video DOT appointment time and contact procedure that is mutually convenient prior to initiation of video DOT.

2. Client will be informed that video DOT is voluntary and may be discontinued (with resumption of face-to-face DOT) at any time at the discretion of the client or provider.

3. Client and public health provider will test the video connection prior to administration of the first video DOT dose. For a mobile phone setup, this should consist of a test video call between the client and provider while the client is in the clinic. For a home computer setup, this should consist of a test video call at a time mutually convenient for the client and provider.

4. Key elements to be verified during the test call:

    a. Video is of adequate quality to observe pills and to visualize the client's open mouth.
    b. Client and public health provider have correct mutual contact identifiers (e.g. phone numbers, Skype ID, etc.)

5. Video DOT should not be initiated until a successful test call has been conducted.

6. The client should be advised to perform video DOT in a private location to preserve confidentiality. Confirmation of the confidentiality of the setting by the video DOT provider is strongly recommended at the beginning of the first few calls, at a minimum. If others are present in the room, the provider should confirm that the client wants to proceed with video DOT while those individuals are present in the room.

7. A successful video DOT call should consist of the following elements:

    a. Provider verifies the identity of the client by visual recognition.
    b. Provider visualizes the pills to be taken and verifies that the doses and medications are correct.
    c. Provider directly visualizes the client swallowing all of the pills.
    d. After the last pill is swallowed, client will display the empty mouth on the video to verify that no pills remain in the mouth.
    e. Provider will speak with the client for at least 30 seconds after ingestion of the last pill as a second check that no pills remain in the mouth. The client should speak during this time, and reciting a standardized phrase (e.g. the alphabet) is encouraged.
    f. Provider will document the DOT visit in North Carolina Electronic Disease Surveillance System (NC EDSS) per standard procedure.

8. If the client wishes to discuss private information with the healthcare provider via video DOT, the provider should remind the client that video DOT (like telephone and internet communication) is not completely secure and confirm that the client wishes to proceed with the discussion via video DOT.

9. Other means of communication (e.g. telephone, face-to-face) should always be offered if the client prefers these to video DOT.

10. Clients should be provided no more than a thirty day supply of medication, and a face to face visit should occur on at least a monthly basis. Medications should be provided labeled in appropriate containers in accordance with NC Pharmacy regulations.

V. REFERENCE PLANS AND POLICIES:

NC Tuberculosis Control Policy Manual/Appendices/Policies and Procedures

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

DENTAL CLINIC
INDEX

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DENTAL CLINIC GUIDELINES AND EVALUATION CRITERIA

DATE DEVELOPED: 10/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/19; 6/24

I. POLICY:

Dentist(s) directly employed, or who contract care for the Division of Public Health Services Dental Clinic, are to provide care in accordance with the following guidelines.

II. PURPOSE:

These standards have been written to allow the dentist(s) a maximum amount of flexibility with which to provide care, and to do so in a manner, which has been determined to be appropriate, and of high quality. Dentists providing care for the Agency Dental Clinic do so recognizing that their performance may be judged by any of the following evaluation criteria, which are directly related to the Guidelines. These standards are an integral part of the Quality Improvement Program.

III. GUIDELINES:

A. The dental clinic staff will provide dental services to eligible clients.

B. Eligibility/Recruitment

The community is informed of the dental clinic services through outreach programs. Referrals may be received from physicians, dentists, hospitals, DSS, various community agencies, schools, client self-referral, and through intra-agency programs at the Division of Public Health Services.

1. Clients will not be coerced to receive dental services. Services are provided solely on a voluntary basis.

2. Acceptance of a particular service is not a pre-requisite to eligibility for receipt of any other program/service involvement or benefits.

3. No person, on the grounds of race, color, age, religion, gender, marital status, national origin, sexual orientation, or handicapped status will be denied services or benefits. Handicapped clients requiring special equipment or expertise may be referred to specialist as warranted.

C. Clinic Schedule:

1. Assessments, treatment, and services are offered by appointment. Appointments are made by the dental management support receptionist **or dental staff**.

2. Appointments are scheduled Monday – Thursday dependent on dentist scheduling and availability.

D. Oral Diagnosis: Client Records

1. The dental record is complete and permits prompt retrieval. All entries are made within the Dentrix Electronic Health Record (EHR) System.

   Method of Assessment: Record review.

2. The dental record clearly documents the client's identification and biographical data (name, social security or identification number, address, phone number, gender, date of birth, name and contact information of any legally authorized representative or individual to be contacted in the event of an emergency).

   Method of Assessment: Record review.

3. The client's positive history of allergic or adverse drug, food or substance reactions noted in the record.

   Method of Assessment: Record review.

4. Pertinent past medical history and current medications (updated every 6 months or start of recorded dental treatment) are documented and easily identified. A new Medical History should be updated annually and reviewed every appointment.

   Method of Assessment: Record review

5. Dental progress notes are sufficient in detail to clearly indicate:

   a. date of service;
   b. procedure;
   c. tooth #;
   d. materials used;
   e. type and dose of anesthesia used;
   f. name and dosage of drugs prescribed;
   g. any additional pertinent information concerning the client or procedure;
   h. signature of treatment provider; and
   i. auxiliary staff signature if they make any entries.

Progress notes should be written out in plain language with minimal use of agency approved abbreviations or symbols. The universal tooth numbering system is recognized as the method of choice for tooth identification.

Method of Assessment: Record review

E. Examination and Diagnosis:

1. Existing hard and soft tissue findings obtained by clinical and radiographic examination are recorded on the client's dental record.

   Method of Assessment: Record review

2. Diagnosis is consistent with findings.

   Method of Assessment: Record review

3. A plan of treatment is available in the client dental record and should be appropriate for the client's age, **function**, and general health. The plan should be sufficiently flexible that it may be altered to accommodate unanticipated changes in the client's status or availability. All changes to the treatment plan should be documented as they are made. The documentations should describe rationales for the change and any further anticipated changes.

   Method of Assessment: Record review

F. Prevention

1. All clients other than those seen only for emergency services have an individualized disease prevention plan based on the client's status and risk factors. The plan may include any of the following:

   a. systemic fluoride;
   b. professionally applied topical fluoride;
   c. self applied topical fluoride;
   d. fluoride toothpaste;
   e. pit and fissure sealants;
   f. preventive periodontal treatment;
   g. tobacco counseling;
   h. oral health instructions and other health education; and
   i. recall examination and prophylaxis.

   Method of Assessment: Record review

2. Each dental prophylaxis provided meets the following standards:

   a. all plaque and other soft debris are removed from tooth surfaces, and the use of disclosing tablets is encouraged;

b. all coronal calculus is removed (includes all supragingival calculus and subgingival calculus up to 3mm below gingival crest).
c. all teeth are polished with prophy paste / rubber cup to remove stain and plaque.

Method of Assessment: Record review for documentation.

3. Children (**under age 21**) presenting with one new smooth surface caries will be treated with topical fluoride at their prophylaxis appointment unless it is determined that they have enamel fluorosis.

Method of Assessment: Review chart for documentation of fluoride applications and the factors supporting or not supporting the decision.

4. Occlusal sealants are placed on susceptible unrestored or incipient carious pit and fissure occlusal surfaces of permanent first and second molars with two years of eruption.

Method of Assessment: Review of client record. Review should reflect that sealants are indicated for deep narrow pits and fissures in a sound tooth.

G. Radiographs: (this section is based upon the American Dental Association 2012 recommendations for prescribing dental radiographs – ADA Council on Dental Materials, Instruments, and Equipment).

1. All radiographic exposures shall be ordered by the dentist according to:

a. Initial Adult Examination:
An initial radiographic examination consisting of posterior bitewings supplemented with anterior and/or posterior periapical films and/or panoramic radiographs as required by oral conditions is recommended for all individuals 15 years and older. Panoramic or full-mouth intraoral radiographic films are appropriate when the client presents with clinical evidence of generalized dental disease, has a history of extensive dental treatment or requires **additional** assessment **including** position of unerupted teeth (e.g.: 3rd molar evaluation)**, or hard tissue pathology evaluation**.
b. Initial Child Examination:
i. Primary dentition (prior to eruption of first permanent tooth) Bitewing films supplemented with anterior and posterior periapical films as required by oral

conditions when interproximal surfaces cannot be visualized or probed.

ii. Transitional Dentition (following eruption of first permanent tooth) Individualized radiographic examinations consist of periapical/Occlusal views and posterior bitewings or panoramic examinations as indicated.

c. Recall Examination:

i. Bitewing and/or periapical radiographs should be taken at intervals as required by the client's general condition and dental health history **at treating dentist's discretion**.

ii. Factors which may require increasing the normal frequency of radiographs at recall examination:

- high level of caries experience
- history of recurrent caries
- existing restorations of poor quality
- poor oral hygiene
- inadequate fluoride exposure
- high sucrose diet
- poor family dental health
- developmentally disabled
- xerostomia
- many multi-surface restorations

iii. In the absence of specific indications for more frequent radiographs, panoramic radiographs or a full-mouth intraoral periapical series should not be taken more often than once every five years.

d. Emergency Examination:
An appropriate diagnostic radiographic examination of the area in question when indicated by signs and symptoms.

Method of Assessment: Review of client dental record and radiographs in client record. Radiographs should be appropriate for the signs and symptoms reported by the client and for the examination provided.

2. Dental Radiographs are dated, identified with the client's name and record number, and securely fixed to the client's dental record or recorded on the computer.
Method of Assessment: Review of client's dental record.

3. Density and contrast of radiographs are such that anatomical hard and soft tissue landmarks can be differentiated and identified.

4. Radiographic image size is not distorted in the area of the mouth under study.

5. Radiographs disclose no overlapping of image in the area of the mouth under study, except where tooth alignment does not permit open contacts.

6. Radiographs disclose no cone-cutting.

7. Bitewing radiographs include the distal surface of the erupted cuspids and the mesial surface of the most posterior erupted teeth.

8. Radiographs adequately target the area requiring evaluation.

   Method of Assessment for #3 through #8: Assess the radiographs within the past year. Applicable criteria used to determine diagnostic acceptability. The anatomy in the area under study should be visible and of diagnostic quality.

Note: If a radiograph has a deficiency, which does not compromise the diagnostic value, the radiograph will be considered acceptable. The peer review process should not encourage unnecessary radiographic exposure. The deficiency should, however, be pointed out to the evaluatee.

H. Radiological Protection

1. All dental auxiliaries who expose radiographs will possess all necessary state certifications to do so.

   Method of Assessment: Observe posting of current staff certificates reviewing necessary documentation.

2. Lead protective devices are used on each client during radiographic exposure.

   Method of Assessment: Observe radiographic procedures directly to determine if protective devices are used in an appropriate manner.

3. The tube housing or cylinder shall be stationary and positioned in close proximity to the film positioning device or skin of the client when the exposure is made.

   Method of Assessment: Observe directly whether the tube housing or cylinder is stationery and within ¼" or less of the film positioning device or skin when the exposure is made.

4. During exposure, radiographic **sensor** is not held in position by attending staff.

   Method of Assessment: Direct observation of radiographic procedure.

5. During exposure, tube housing or cylinder is not held by attending staff.

   Method of Assessment: Direct observation of radiographic procedure.

6. Operator is at least six feet from patient and not in the path of the primary beam or stands behind protect barrier during exposure.

   Method of Assessment: Direct observation of radiographic procedure.

7. Only necessary persons allowed in radiographic area during exposure.

   Method of Assessment: Direct observation of radiographic procedure.

I. Restorative

1. Treatment is explained to the client (parent/verified personal representative) before services begin, both at time of examination and repeated prior to treatment.

   Method of Assessment: Direct observation of clients at time of examination and at initiation of treatment.

2. Tooth preparation and restoration are designed to make the best use of current materials and operative techniques to minimize trauma to the tooth and client while providing best esthetics and longevity of the restoration.

   Method of Assessment: Direct observation of completed restorations.

3. Esthetics of anterior restoration satisfies the requirement for color and contour of the adjacent teeth.

   Method of Assessment: Direct observation of completed restorations should reveal that they are aesthetically acceptable, and not displeasing to the client. The client may be asked to comment on the appearance of the restorations.

4. Instructions concerning restorative care are given to the client (parent/verified personal representative) postoperatively, and services planned for the next appointment are explained.

   Method of Assessment: Direct observation of completion of a restorative Dental appointment and/or review of the record to reveal documentation that post-op instructions were provided.

J. Pediatric Dentistry: Treatment Planning in the Primary Dentition.

1. It is recommended that primary posterior teeth with three or more carious surfaces or teeth receiving pulp therapy be restored with bonded composition or stainless steel crowns.

   Method of Evaluation: Record review.

2. All carious teeth are addressed in the treatment plan. In some instances that may simply imply observation, it should, however, be documented as such.

   Method of Assessment: Record review.

3. Carious primary incisors should be restored if caries involve but one surface. If the dentist elects to restore carious primary incisors having multiple carious surfaces the treatment of choice is full coverage crowns.

   Method of Assessment: Record review.

K. Behavior Management of Pediatric Clients

1. Behavior management of children shall be limited to voice control. No physical restraints will be used. Children who are unable to be controlled by these criteria shall be referred to a pediatric dentist.

   Method of Assessment: Record review.

2. The response to behavior management techniques, if used for clients less than six years of age, is noted in the progress notes.

   Method of Assessment: Record review.

L. Periodontics

1. When applicable, the record contains a written diagnosis by ADA-Case Type (Gingivitis, Early Periodontitis, Moderate Periodontitis, and Advanced Periodontitis). Note: because our client population has very many primary dental needs, periodontal therapy is usually limited.

   Method of Assessment: Record review.

2. The record contains the radiographic survey and periodontal probing values recorded on the visit when the initial periodontal evaluation occurred.

   Method of Assessment: Record review.

3. Periodontal treatment is documented, and consistent with the need indicated by initial diagnosis.

   Method of Assessment: Record review.

M. Removable Prosthodontics

1. Pre-treatment full-arch radiographs are available for all removable prosthetic clients (a panographic or full mouth intra-oral series).

   Method of Assessment: Record review.

2. The overall oral condition and the condition of selected abutment teeth possess adequate integrity to assure success of the intended prosthetic appliance.

   Method of Assessment: A review of the radiographs, clinical exam, endodontic status, and perio charting will be used.

3. The appearance of the denture is aesthetically acceptable to the client.

   Method of Assessment: The denture harmonizes with the client's facial appearance. The positioning and shade of teeth appear natural. Vertical dimension is within normal limits. The client expresses satisfaction with appearance of the prosthesis **and will sign the Try-In Consent form before final completion is sent to the lab.** Documentation should be made in the record as to the client's acceptance of the esthetic appearance of the prosthesis.

4. Denture stability/retention is within normal limits.

   Method of Assessment: Ask client if dentures stay in place when eating and speaking. The stability / retention of the prosthesis is consistent with the limitations imposed by the ridge anatomy present.

N. Oral Surgery: Indirect evaluation of extractions/surgical procedures:

1. The diagnosis leading to extraction or other surgical procedure is written in the dental record and is consistent with clinical findings.

   Method of Assessment: Review of the client's dental record will determine whether documentation for the diagnosis is recorded, including the availability of a preoperative radiograph. History, clinical symptoms, problem assessment and diagnosis are noted in the client's dental record in a SOAP or **provider's chosen** format.

2. Appropriate diagnostic preoperative x-rays are available in the client's dental record.

Method of Assessment: Review of radiograph to assess presence of the entire tooth including the apex of the tooth (teeth) and surrounding pertinent anatomy.

3. All pathology reports based on cytology or biopsy are present in the client's record.

   Method of Assessment: Review of the client's dental record. The dentist shall record results in the client's progress notes. When a tissue biopsy is performed, the client's record must include documentation or indication for biopsy, a copy to the pathology report, and evidence that the client was notified of the result and received proper follow-up.

4. Appropriate preoperative systemic antibiotic therapy is provided to clients requiring such, as specified by the American Heart Association.

   Method of Assessment: Review of the client's medical history record. Observe that those clients having noted a history of health problems suggesting antibiotic coverage have been questioned and/or their physician has been consulted for direction on the need for antibiotic coverage for any and all invasive dental procedures. If a prescription is written, it is documented that the client has complied with the regimen prior to such procedures.

O. Direct Observation of Surgical Extractions

1. Standard principles of flap design have been accomplished, e.g. Occlusal portion of flap design to extend at least one tooth adjacent to the interdental papillae both mesially and distally from the tooth to be extracted (exception to this would be extraction of the most distal tooth in the arch). Vertical incisions extend obliquely so that the base of the flap is wider than its apex, the tissue of the retracted flap is not mutilated or torn, and the flap is full thickness in that it is not separated from the periosteum.

   Method of Assessment: Observe the surgical flap procedure on clients present in the clinic receiving this service, or observe the flap design of revisit clients who receive this service and are present in the clinic for post-operative follow-up or suture removal.

2. Pathologic tissue is completely removed. There is no evidence of residual periapical or periodontal pathology, including root fragments at the surgical site, unless removal is contraindicated.

   Method of Assessment: Direct observation. If root fragment has been retained, client record should indicate that the client was informed of the decision not to pursue further surgery and the reason for the decision.

3. Alveolar margin is smoothed and displaced fragments of the alveolus and foreign particles are removed.

   Method of Assessment: The examiner assesses these criteria by appropriate instrumentation and palpation, including a postoperative radiograph of the operative site when deemed necessary. When clients present in the clinic for postoperative follow-up or suture removal, the examiner may assess these criteria by palpation of the operative site.

4. Soft tissue flap is repositioned into anatomical position and maintained there with suture or gauze pressure pack.

   Method of Assessment: Inspect the surgical flap site to make certain the soft tissue is repositioned appropriately over the alveolar bone without excessive tension.

5. Oral and written instructions concerning postoperative care of surgical or extraction services are given to client (verified legal representative) and documented in the record.

   Method of Assessment: Observe whether oral and written instructions concerning postoperative care of surgical and/or extraction sites are given to the client before dismissal.

6. Informed consent is obtained for oral surgery procedures. This should include a discussion of risks, benefits, and alternatives to treatment.

   Method of Assessment: Review the client's record and observe the dentist providing informed consent discussion to a surgery client prior to care. Discussion should include risks, benefits, treatment alternatives, client's signature, dentist's signature and date.

P. Orthodontics

All clients requesting orthodontic treatment or manifesting signs and symptoms suggestive of need for orthodontic treatment will be referred out.

Method of Assessment: Record review.

Q. Drugs

1. Drugs prescribed for and/or administered to dental clients are recorded in the client's dental record.

   Method of Assessment: Review of dental record and appropriateness of prescribed drugs and dosage for the written diagnosis.

2. Drugs administered or prescribed are consistent with the written diagnosis.

   Method of Assessment: Review of dental record for appropriateness of prescribed drugs and dosage for the written diagnosis.

3. Appropriate preoperative, systemic antibiotic therapy is provided clients requiring such, as specified by the American Heart Association.

   Method of Assessment: Review client's medical history. Clients indicating history of conditions, which place them at risk for Subacute Bacterial Endocarditis (SBE).

4. All suspected adverse drug reactions are recorded in the dental history and reported as outlined in the Adverse Drug Reaction section of the Procedures for Pharmacy Services. Any allergies to medication(s) are prominently recorded in the record. If no drug allergies exist, the acronym NKDA (no known drug allergies) shall be documented in the record.

   Method of Assessment: Review of client's dental history and progress notes in the record.

5. Prescriptions which are called into a pharmacy shall be entered into the client's dental record at the time of the call.

   Method of Assessment: Review of clinic protocols with the Dental Director and/or office manager.

6. All drug stocks must be checked for expiration. All expired medication must be disposed of in accordance with Agency policy.

   Method of Assessment: Review of clinic logs at peer review audits.

R. Emergency Care

Basic emergency diagnostic and treatment equipment shall be available in case of life-threatening episodes.

All equipment is maintained and ready to use at all times:
- O2 tank is full;
- AED monthly BIT is completed;
- Ventilation Mask is attached to AED for immediate use when needed.

Method of Assessment: All dental clinic staff has current certification in Healthcare Provider Basic Cardiac Life Support (BCLS), and have been trained to call a code, notify 911, know where the O2 and automated

external defibrillator. (AED) are located, and are trained to competently use this equipment under the guidance of the Dental Director and Physician Extenders.

S. Environment

All housekeeping activities have been performed before clinical day begins.

Method of Assessment: Observe the cleanliness and neatness of all areas of the dental clinic. If observation in the morning is not possible, then question the dental staff in accordance with the acceptability of the housekeeping activities being provided. Suggested areas to be considered are cleanliness of floors, walls, furniture, cabinets, dental chairs, dental units, wastebaskets, reception room tables, etc.

T. Infection Control Practices in the Dental Treatment Environment

1. An infection control policy for the dental clinic has been reviewed and approved by the clinics infection control committee/officer.

   Method of Assessment: The infection control policy for the dental clinic is accessible and available for review by the dental clinic staff.

2. The requirements of the OSHA Bloodborne Pathogen Standard are met by having documentation of an exposure control plan, training and immunization record.

   Method of Assessment: Review of the dental clinic staff, personnel records, and direct observation. All dental staff have been given the opportunity to be immunized for Hepatitis B and other diseases. Personnel records should provide dates of Tuberculosis skin testing (PPD). Follow-up action is documented for employees with a positive finding or conversion, which requires attention.

3. Accepted infection control procedures are practiced prior to, during and after client care.

   Method of Assessment: Direct observation.

4. A written schedule should exist which describes general sanitation and housekeeping procedures for the dental clinic. Housekeeping services should be available to remove refuse daily and to clean floor coverings.

   Method of Assessment: Review Dental Clinic Infection Control Manual.

U. Client Preparation:

1. Receptionist shall perform the following tasks for every client visit upon their arrival to the dental clinic:

   a. When client checks in they may, if convenient, sign client register provided a method is used which precludes their viewing of the names of any other clients (i.e. adhesive labels, sign-in cards, etc.);
   b. Retrieves client's record in Dentrix EHR and confirms that client's birth date matches that of client being seen;
   c. Confirms that needed pre-medications, as indicated on dental record, have been taken the prescribed period of time before being seated in the treatment room; and
   d. Updates client's appointment status in the Dentrix system to notify clinical staff of client's status for appointment.

   Method of Assessment: Observe client preparation procedures accomplished by dental receptionist.

2. Chairside dental assistant shall perform the following tasks at each dental client visit:

   a. Escorts client to a prepared treatment room;
   b. Confirms client's identity by matching birth date of client with that on the client's dental record;
   c. Verifies that treatment plan for this appointment is the same as that anticipated by the client, and that it addresses the client's immediate needs;
   d. Reviews medical history and **updates in Dentrix at each appointment**. If medical history is older than **1 year**, have client complete a new Medical History form.
   e. Reviews medical alerts **in Dentrix**, confirming that necessary pre-medications have been taken the prescribed period of time prior to the appointment; and
   f. Introduces the client to the dentist as he/she enters treatment area, reviewing treatment planned, pre-medication taken (if required), and other medical conditions known to the assistant which should be brought to the attention of the dentist.

   Method of Assessment: Observe client preparation procedures accomplished by chair-side dental assistant.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SCHEDULE OF ORAL HEALTH SERVICES

DATE DEVELOPED: 8/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

The Division of Public Health Services Dental Clinic provides oral health services to clients. The Agency Dental Clinic utilizes established dental procedures, dental clinical guidelines and clinical evaluation criteria recommended by the American Dental Association. These services have been defined using CDT Codes, when available, to meet federal and state reporting requirements for reimbursement.

II. PURPOSE:

The schedule of services was developed to comply with an administrative interpretation of requirements of law and regulations described in the *Health Centers Consolidation Act of 1996* and the *Code of Federal Regulations*, *51c Grants for Community Health Services, revised 1996* as well as the Human Services (DHHS) priorities as described in the draft publication entitled *Bureau of Primary Health Care Oral Health Policy and Program Expectations for Community and Migrant Health Centers (1997).*

III. GUIDELINES:

A. The Dental Director is responsible for developing a primary oral health care plan, which addresses the needs of the community based upon financial feasibility.

B. The quality of dental care provided by the Agency Dental Clinic shall be subject to continual monitoring and review. The Improving Organizational Performance Program shall include the following:

1. A quality workforce – will insure that a high quality of dental personnel provide dental services through recruitment and selection efforts and the credentialing process.

2. A high standard of professional care – will insure that a high quality of professional care is provided through a carefully structured, active review of dental services through regularly scheduled chart audits. The audits will focus upon appropriateness of care, comprehensiveness of care, and continuity of care.

3. A high standard of service delivery – will insure that clients are satisfied with clinic accessibility and client care through regular client satisfaction surveys.

4. A continuing performance improvement of health status outcomes – will insure that the clinic is provided with a mechanism to record, review and improve certain quantifiable health outcomes consistent with the Health care plan adopted by this organization.

C. The scope of services for a Primary Oral Health Care Program are comprised of the following services and activities:

1. LEVEL I SERVICES – Acute Emergency Dental Services:

Emergency dental services are those necessary for the relief of acute problems involving the face, jaw, and teeth requiring immediate or urgent care. Emergency dental care services include all necessary procedures to manage the emergency, and stabilize the client. Services that eliminate acute infection, control bleeding, relieve pain, and treat injuries to the maxillofacial and intraoral regions

- Activities – diagnosis, pulp therapy, tooth extraction, palliative or temporary restorations and fillings, periodontal therapy, and prescription of medications.

2. LEVEL II SERVICES – Prevention and Diagnosis:
Prevention and diagnostic services include those services intended to prevent the onset of the dental disease process. Prevention and diagnostic care may be directed at an individual or a community. Services that protect individuals and communities against disease agents by placing barriers between an agent and host and/or limiting the impact of a disease once an agent and host have interacted so that a client/community can be restored to health.

- Activities – professional oral health assessment, dental sealants, professional applied topical fluorides and supplement prescriptions where necessary, oral prophylaxis and client education on self-maintenance and disease prevention.

3. LEVEL III SERVICES – Treatment of Dental Disease/Early Intervention Services:

Treatment of dental disease through early intervention includes those services deemed necessary to control the early stages of

disease. These services are not complicated in nature and usually more than one procedure can be accomplished in an appointment. These services constitute the majority of dental clinic activities and include diagnosis and treatment on common oral diseases such as caries and periodontal diseases as well as less common oral conditions such as developmental abnormalities or abnormal growths, oral, nasal and pharyngeal infection. These functions include basic dental services that maintain and restore oral health function.

- Activities – restorative services which include dental fillings and periodontal services; space maintenance procedures to prevent orthodontic complications for clients 3-13; and simple endodontic therapy.

4. LEVEL IV SERVICES – Rehabilitative Services:

Rehabilitative services include high quality reasonably priced solutions, which replace missing teeth. These services include the fabrication of removable partial dentures, full dentures and single or multiple-unit fixed prosthetics. Also included are elective oral surgery, orthodontics and other specialty services. Rehabilitative Services include the provision of low cost solutions to replace dentition that would allow a client to obtain employment, education, and/or enhance self-esteem.

- Activities - fabrication of removable prosthetics such as dentures and partial dentures.

D. The clinical guidelines and evaluation criteria have been designed to allow the Dental Director adequate latitude to develop a dental plan that is effective based upon the needs of the community and resources available to the Agency Dental Clinic.

E. These protocols do require that all dental treatment meets or exceeds the accepted therapeutic guidelines of the American Dental Association as well as other relevant program regulations.

F. The aforementioned levels of care are prioritized. The lower levels of care include services, which are:

1. The most frequently needed;
2. The least costly to provide in terms of manpower or dollars, and;
3. Those which produce the greatest long-term benefits to oral health in the community.

The provision of emergency care has been considered mandatory and thus, it forms the first level of services. After Level I, those services which prevent oral disease, have been given greater priority than those intended to contain a disease process or to correct the damage caused by the consequences of disease.

G. The schedule of services and clinical guidelines are intended to provide direction for the staff of the Agency Dental Clinic. The dental director may use the schedule of services as a guide to develop a dental care delivery system sensitive to the needs and desires of the community while maintaining assurances that the cost-effective services are provided.

H. It should be noted that while the prioritized levels of care identify those services which will provide the greatest good to the greatest number in a community, administrators and the dental director must consider the benefit to the financial viability of their program which may be obtained through the inclusion of level IV services. Level IV services, while elective in nature, are less cost effective because of the associated additional lab fees and therefore these services may be limited according to the financial resources available to the Agency Dental Clinic.

I. The Division of Public Health Services Dental Clinic shall endeavor to maintain regular clinic hours of operation, which shall best meet the needs of the community being served.

J. It shall be the intent of the Agency Dental Clinic to provide dental services to the target population.

K. The Agency Dental Clinic shall maintain adequate flexibility in their appointment scheduling system to allow for evaluation of emergency problems, walk-in clients, clients with special problems and new clients. It is understood that should the demand for care exceed the Agency Dental Clinic's capability to provide such care, it may be necessary and appropriate to take measures to place limitations on the availability and nature of that care. Limitations or exclusions of care must take into consideration the clinic's various contractual commitments, the clinic size, staffing, and financial resources.

L. The Agency's Dental Clinic shall endeavor to facilitate client flow by employing such measures as:

1. Closely following the schedule within the Dentrix system which is easily accessible by all dental and dental assisting staff;

2. Allowing dental staff complete appointment book control;

3. Maintaining a well-trained chairside assisting staff, preferably certified to provide all expanded functions allowed by the NC's Dental Practice Act;

4. Maintaining dental equipment to prevent down time of a portion of the clinic;

5. Maintaining an adequate supply of sterile instruments and supplies;

6. Adequate cross-training of staff to allow for unexpected absences of critical staff;

7. Insuring that auxiliary staff are trained to minimize the efforts of the dentist by adequately preparing client and treatment rooms, i.e. all instruments required for initiating care are at hand, lipstick removed, napkin placed, operatory fully equipped with sterile handpiece, etc.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DENTAL CLINIC RECORD POLICY

DATE DEVELOPED: 8/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/24

I. POLICY:

The Division of Public Health Services Dental Clinic shall maintain a clinical record on each client receiving services through the dental program. The clinical record contains pertinent past and current dental, medical, social, and therapeutic information. All dental services, whether through direct client care or phone interviews are documented in the clinical record. Each dental clinic employee is responsible for their own documentation. Also, any interaction with the client's primary care provider should be documented in the clinical record. A note must be written for each encounter made.

II. PURPOSE:

To maintain the required information for each client seen through the Agency Dental Clinic in order to collaborate services and provide a more holistic approach to their dental care.

III. GUIDELINES:

A. The Agency Dental Clinic client record shall contain the following:

1. Radiographs
2. Copy of client's insurance/Medicaid card or household income documentation for grant money guidelines
3. Client Registration Form, signed by the client
4. Medical History (**updated each appointment**); new form updated annually
5. Dental Examination
6. Progress Notes
7. Miscellaneous tab within the Dentrix EHR system:
   a) HIPAA Acknowledgement form (all patients)
   b) Treatment Authorization Statement (Patient Information Sheet)
   c) Terms and Conditions (all patients yearly)
8. Correspondence

B. All client registration data is entered into the Dentrix EHR computer database of the agency. The registration form is scanned in the client's record.

C. Client dental records are maintained in the Agency Dental Clinic and are considered Protected Health Information (PHI) as required by HIPAA Privacy Regulations.

D. The Agency Dental Clinic employees are required to attend orientation and annual HIPAA Privacy Training. Under no circumstances is PHI to be shared with any person other than staff who have a need to know related to treatment, payment or healthcare operations related to the provision of dental health care.

E. A separate data grouping may be kept for client recall information. This data may be kept apart from the dental clinic record and may include information only pertaining to client record number, client name, address, telephone number, names of parents or verified legal representative and dates of anticipated recall appointments. This data should not contain health care information.

F. Clients who desire a copy of their dental clinic record set shall be granted access upon meeting guidelines outlined in the Agency HIPAA Policy, Accommodation of Client Right to Access Protected Health Information. Under no circumstances may any staff member turn over or lend the original copies of client dental records or x-rays to clients, or their verified personal representative.

G. Quarterly Dental Program Audits will be performed to monitor the provision of care, documentation, and billing as part of the Improving Organizational Performance (IOP) Quality Assurance Program.

H. Interpreter services are utilized for the limited English proficient clients. The clinical professional will document care provided. The name of the interpreter will appear on the chart.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMERGENCY DENTAL CARE

DATE DEVELOPED: 8/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services Dental Clinic shall make every effort to assist clients requiring emergency care or who are referred for dental emergencies from other clinics, physicians or physician extenders.

II. PURPOSE:

From time to time, clients will present with serious dental emergencies in the dental clinic. This policy outlines measure that may be taken in response to clients in need of emergency dental care.

III. GUIDELINES:

A. Clients may be referred for dental emergencies in the following manner:

1. The dental clinic shall see a client for immediate treatment, or
2. After an examination, the client will be prescribed appropriate medications to relieve pain and/or infection until an appointment can be scheduled, or
3. A client may be referred to an appropriate primary care clinic for medical evaluation and needed prescriptions until the dental clinic can schedule an appointment for required care, or
4. The client may be referred to another dental office, or
5. The client may be referred to the nearest hospital emergency room.

B. The dental clinic shall block appropriate units of time to accommodate clients needing emergency care and for referrals from other sources.

C. The dentist may deem it necessary to refer a client to another office if:

1. Neither the dental clinic nor the medical clinic is able to provide the necessary care required.
2. The dental clinic determines that the client would be better served in a different setting or requires services that the dental clinic cannot provide.

D. When a client is referred to an outside provider for required services, the following procedure must be followed:

1. The dentist or a member of the dental staff shall contact the dentist, physician, or physician extender concerning the nature of the referral or a written referral form will be given to the client.
2. The dentist or the dental clinic staff shall document the referral in client's dental record and include the following information:

    a. the date the referral was made;
    b. referral source name and telephone number; and
    c. the date and time of the client's appointment with the referral source, if the dental clinic staff scheduled the appointment.

3. All correspondence with the referral source will be documented in the client's dental record including follow-up letters, reports and/or radiographs.
4. If a referral form was completed, it is to be placed in the client's clinical record, and a copy will be sent with the client with the appropriate referring information listed.

E. During weekends, after hours or holidays the Dental Clinic will be closed. Clients are instructed per dental phone voice mail on the following:

You have reached the Rockingham County Dental Clinic. The office will be closed for dental services from _____ to _____. Dental services for scheduled appointments will resume on _____. If you have a dental emergency on a weeknight, holiday or weekend, you may seek medical help at the hospital emergency room or your family physician. If you would like to leave a message regarding an appointment just wait for the beep.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DENTAL CLINIC QUALITY IMPROVEMENT PROGRAM

DATE DEVELOPED: 8/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/22

I. POLICY:

The Division of Public Health Services Dental Clinic will strive to maintain the highest quality of dental care possible by insuring a high quality workforce through a careful recruitment and selection effort. The Agency participates in a Quality Improvement Program to assure compliance with all federal, state, local and Agency guidelines and regulations.

II. PURPOSE:

The Quality Improvement Program is an ongoing program that continually assesses quality of services provided to clients of the Agency.

III. GUIDELINES:

A. Clinic productivity and dental clinic staff productivity shall be evaluated by any number of methods, including but not limited to:

1. Measures including those associated with Relative Value Units will be utilized. These values evaluate the efficient use of a provider's time and determine the number of fifteen minute measures of time that a provider expends providing client care for a specific procedure.
2. Financial activity reports also evaluate dental clinic staff productivity. It is crucial that the dental clinic generate adequate income to maintain its financial viability. The Dental Director shall recognize and accept the administrative responsibility for the program.

B. Client encounters, which have historically been the basic productivity measure, will continue to be monitored. It is recognized that the amount of time required for various procedures can vary from a few minutes to a few hours. Thus, the number of client encounters in the dental clinic can be highly variable from day to day.

C. Quality clinical care shall be assured through an active carefully structured dental record. Documentation of care within the record shall focus upon appropriateness, comprehensiveness, and continuity based on regularly

scheduled quarterly record audits. The information generated by the dental program audits shall be used by the dental director and dental staff to formulate methods of improving the care provided to the dental clinic clients.

1. A minimum of 10 clients served during these quarters will be reviewed. All disciplines will be included in the record audit.
2. The purpose of the record audit will be to:
   - Ensure that the level of dental care specified by the policies and dental codes, procedures and protocols of the dental program are being met.
   - Discuss problems in the dental clinic and make recommendations to correct deficiencies found.
3. Chart selection will be based on randomly selected records from the quarter in review.
4. The results of the audit will be tabulated and recorded in minutes and filed within the dental clinic. Information discussed within the report will have the client MR number, rather than any other identifying data.
5. The strengths and weaknesses will be identified and summarized along with a corrective plan of action.
6. A program annual evaluation will be completed with the dental clinic director/dentist and the staff development coordinator. This annual summary will include the results of the fiscal year quarterly audits, the program strengths and weaknesses, changes that occurred within the program and any areas of improvement as addressed for the upcoming year.
7. At the end of the fiscal year, we will review programs to identify any unmet needs and establish guidelines for the upcoming fiscal year.

D. Other measures of assuring quality service will be the investigation of client complaints, which relate to the quality of care provided in the dental clinic. All complaints shall be documented and reviewed with the Agency staff involved and measures will be identified to prevent future occurrences.

1. Client Satisfaction Surveys are located on the county website with a link to access the survey. Clients are asked to complete the survey at the completion of their dental appoint and are provided with the link to the survey via the client walkout statement. Client satisfaction surveys will be used to evaluate the manner in which the dental clinic delivers care. Surveys will be evaluated by the Agency to identify methods of improving the way in which dental care is delivered.

2. Staff will be notified of comments and results. Areas for improvement will be addressed.
3. Attempts will be made to seek every client's participation in completing the surveys.

E. The dental clinic shall endeavor to create measures that help improve services delivered to our clients. Quality shall always be an issue of key consideration with the Agency Dental Clinic. As such, our efforts to track quality will continually be evolving. The measures utilized currently will be revised as our program develops improved methods of documentation, newer treatment modalities and clinical techniques, and enhanced care delivery procedures.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DENTAL CLINIC RISK MANAGEMENT

DATE DEVELOPED: 9/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services Dental Clinic shall provide dental care utilizing current recommended modalities to prevent litigation related to issues of care provided by the dental clinic staff.

II. PROCEDURE:

A. The increasing influence of litigation on dentistry has resulted in an effort by the profession to reduce the risk of legal liability by closely examining all aspects of client care. The purpose of this review process is to provide the best possible client care and to reduce risk factors.

B. In most situations, miscommunication and misunderstanding between the dentist and client is an important contributing factor. This policy reviews concepts of liability and risk management and discusses methods of risk reduction.

C. The most important factors in risk reduction are good documentation and good communication.

III. GUIDELINES:

A. The foundation of dental practice is based on evidence-based medicine. In addition to excellence in clinical practice, other aspects of client care may significantly affect liability. These include:

1. Dentist-client communication;
2. Client information;
3. Informed consent;
4. Proper documentation, and;
5. Appropriate management of complications.

B. One method of improving the dentist-client relationship is to provide clients with as much information as possible on any specific problems that the client may have, their relationship to overall health, and methods of managing them. Well-informed clients generally have a much better understanding of specific problems and more realistic expectations about

treatment outcomes. Efforts by dental practitioners to provide information to clients generally improve client rapport.

C. Clients value and expect a discussion with their dentist about their care. Brochures and various other types of informational packages are often very helpful in providing clients with both general and specific information about general dental and oral surgical care. Clients who need oral surgical, periodontic or endodontic care will benefit from information on the nature of their problem, recommended treatment, alternatives, expectations, and possible complications. This information should have a well-organized format that is easily understood and is written in layman's language. When a dentist has a specific discussion with a client or gives a client an informational package, it should be documented in the client's chart.

D. The current concepts of informed consent are based on providing the client the necessary information and obtaining a consent signature for a procedure. In addition to fulfilling the legal obligations, there are several benefits of obtaining the proper informed consent from clients. First, well-informed clients who understand the nature of the problem and have realistic expectations are less likely to be unhappy or behave litigiously. Second, a properly presented and documented informed consent can prevent unmeritorious claims based on misunderstanding or unrealistic expectations of the client. Finally, obtaining informed consent offers the dentist the opportunity to demonstrate greater personal interest in the client's health and welfare. Greater client acceptance and understanding of treatment pros and cons leads to greater rapport.

E. The dentist should discuss all aspects material to the client's decision to undergo treatment, even if it is not customary to provide such information. When a reasonable person is likely to attach significance to an adverse or unpleasant event during or after a procedure, it is considered a material note.

F. Informed consent consists of three phases:

1. Discussion,
2. Written consent
3. Documentation in the client's record

G. A discussion of the appropriate issues should take place between the dentist and client, or the parent/verified legal representative if the client is a minor. In addition, at least one witness must be present during this discussion. This can be an auxiliary person from the dental office, the client's spouse

(or an interested participant) or both, if possible. The witness's signature on the informed consent document not only verifies the client's signature but also verifies that the information was actually presented to the client.

H. The discussion should include information about:

1. The specific problem;
2. Proposed treatment;
3. Anticipated common side effects;
4. Possible complications and frequency of occurrence;
5. Anesthesia;
6. Treatment alternatives; and
7. Uncertainties about final outcome, including a statement that the treatment has no absolute guarantees or warranties.

I. The Agency Dental Clinic has developed informed consent documents in both English and Spanish. They are to be used prior to any oral surgery or endodontic procedure. The information must be presented so that the client has no difficulty understanding it.

J. At the conclusion of the discussion the client must be given an opportunity to ask any remaining questions.

K. After the discussion, the written informed consent must be signed by the client, the dentist, and a witness. The written consent must include each of the items presented in the discussion, described in easily understandable terms.

L. Staff will inform the client that translator services are available on site. If the Division of Public Health Services staff translation services are utilized, the first and last name of the translator needs to be identified within the documentation on the client's record. Some clients may choose the interpretive assistance from a family member or friend. If so, staff should inform the client that confidential information may be revealed. Then allow the client to choose their translator source. Minor children (under 18 years of age) should not be used as the interpreter unless it is an emergency service or extenuating circumstances where the client's services are needed right away and no one else is available. If the client chooses to continue with the family member as the interpreter, this should be documented within the client's clinical record and documented that the Division of Public Health Services' Interpreter services were available and offered. The program area should have the "Declination of Interpreter Services Form" completed and signed at each visit in which interpreter services are declined.

M. An individual who speaks but does not read a language provided on the consent form shall receive the discussion in their language by a member of the dental staff. This situation being far from ideal must be extremely well documented. The client, translator, and a staff member should all sign the English document indicating that a foreign language translation was preformed providing the name of the interpreter.

N. To ensure that the client understands each specific aspect of the written consent form, each paragraph may be individually initialed.

O. At the conclusion of the discussion, the informed consent document shall be signed by the client, the dentist, the interpreter (if one was required), and at least one witness. In the case of a minor, the informed consent should be signed by the parent or verified legal representative.

P. The third and final phase of the informed consent procedure is to document in the client's record that an informed consent was obtained. This documentation may include a note stating that the discussion took place. The written consent form is filed in the client's record under the consent tab, to verify consent.

Q. There are three special situations in which an informed consent may deviate from these guidelines:

1. A client may specifically ask not to be informed of all aspects of the treatment and complications (this must be specifically documented in the record).
2. It may be harmful in some cases to provide all of the appropriate information to the client. This is termed the therapeutic privilege for not obtaining a complete informed consent. It is somewhat controversial and would rarely apply to routine dental or oral surgical procedures.
3. A complete informed consent may not be necessary in an emergency, when the need to proceed with treatment is so urgent that unnecessary delays to obtain an informed consent may result in further harm to the client. It should be noted that while many dental conditions may seem urgent in the eyes of the dentist, the reality is that most can be stabilized without invasive procedure, allowing the client time to confer with family members or even seek a second opinion.

R. In spite of the best efforts in diagnosis, treatment planning, and technique, the outcome of a procedure is sometimes less than optimal. A poor result does not necessarily suggest that a practitioner is guilty of negligence or

other wrongdoing. If significant medical complications occur during a procedure, the dentist shall immediately address the problem in the most appropriate manner.

S. The dentist should discuss the nature of the complication with the client. Examples of such situations are loss or failure to recover root tip, perforation of the maxillary sinus, damage to adjacent teeth, inadvertent fracture of surrounding bone, separated endodontic file, etc. In these instances the dentist should clearly outline proposed management of the problem including specific instructions to the client, further treatment that may be necessary, and referral to an oral surgeon, endodontist, periodontist, etc. when appropriate.

T. In some instances untoward events result from errors, for example extraction of the wrong tooth. As soon as the error is recognized, it should be honestly discussed with the client. It is best to consider practical treatment options, which can produce a reasonable outcome and appropriate treatment. In many such instances a referral to a specialist should occur in order to help determine the most appropriate action. If a problem occurs with a child, the parents or verified legal representative should be notified immediately. The dentist must assume the responsibility of discussing the situation with the parents and recommending solutions that may remedy the problem.

U. It is essential to notify the malpractice carrier of any situation, which might lead to litigation. Clearly if a client threatens to discuss the problem with an attorney the malpractice carrier must be notified. It is important to refrain from arguing with the client or the client's verified legal representative. Finally, it is imperative that the record accurately reflects the details of the occurrence. No additions, deletions, or changes of any sort should be made to the original documentation of the event. Records must not be misplaced or destroyed according to the Agency records retention policy.

V. Avoiding Client Abandonment: Having accepted a client for care and initiated treatment, the dentist is obligated to provide care until the treatment is terminated. There is an obligation of the Division of Public Health Services to continue to treat clients.

W. Client Termination: If a situation should arise in which the dentist-client relationship has been damaged to the degree that client care should be terminated, the dental director must follow certain steps before discontinuing treatment to avoid being accused of client abandonment. They are:

1. Approval to terminate care must be obtained from:

    a. The Rockingham County attorney
    b. The Division of Public Health Services Director

2. A letter must be sent to the client, indicating the intent to withdraw from the case and terminate care at the Agency dental clinic.

    a. The letter must explicitly include the reasons for the decision to discontinue treatment, and
    b. The letter should be sent by certified mail to ensure that the client does in fact receive it.

3. The dentist must continue to remain available for treatment of emergency problems for 30 days.
4. The dentist must offer to forward copies of all pertinent records that affect client care.

X. In addition to providing the best technical care, the dentist must address several other aspects of client care to minimize unnecessary legal liability. The dentist should develop the best possible rapport with clients through improved communication, providing any information that may improve their understanding of treatment. Adequate documentation of all aspects of client care is also necessary.

Peterson, Ellis, Hump, Tucker: Contemporary Oral and Maxillofacial Surgery, C.V. Mosby Co. 12:285-288, 1988

Rev /di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

DENTAL CLINIC ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A. Division of Public Health Services 1. Mission, vision, goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B. Review of Policies: 1. Agency Safety a. Fire Prevention and plan b. Smoke Sensors c. Fire Extinguishers d. Exit Signs e. Security f. Tornado Plan g. Emergency Preparedness - Automatic External Defibrillator - Dental Clinic Disaster Training - Dental Clinic Disaster Assistance - Emergency Shelters and Team Assigned		
2. Personal Safety a. Agency worksite b. Vehicle Safety c. Threatening behavior d. Medical emergencies - Clients - Employees - Staff training for: * CPR * Automatic External Defibrillator * Infection Control		

3. Infection Control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and Handling Supplies g. Standard Precautions h. Blood borne Pathogens i. Vaccinations * TB Skin Test * Hepatitis B or Waiver * Rubella * Tetanus * Influenza * Varicella j. Equipment Management * Vaccine transporting * Handling & Storage k. Identifying, Handling and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment * Gloves * Impermeable Gown * Antibacterial Hand Wash * Spill Kit * N-95-Respirator Mask * Goggles/Face Shield		
C. Preceptor Assigned		
D. Orientation Period		
E. Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable) 4. Pager system 5. Scope of services and program policy review 6. Dental Clinic a. Charting System – * Health History – Updated every year * Patient Information with demographics * Treatment Plan * Progress notes * Copies of radiographs * Consents for treatment * Narratives are written with date and		

services rendered – including notations for follow-up * referrals are documented b. Dentrix charting system c. Documentation (if having to use paper charts) * How to correct entries * Writing neat and legible * Most recent note on top * Dental staff – hygienist have direct supervision * Consents Forms/Release of Information * Consent to photograph * Dental approved – standardized abbreviations * Client referral form * Follow-up of abnormal findings * Encounter Form		
7. Dental Clinic Expectations of the Dental Staff * Report to clinic as assigned in a timely manner * Review chart prior to client contact * Introduce self to client & state purpose * Use appropriate communication skills * Assess needs, health history, and current status/document appropriately * Implement and document problems based on assessment * Implements, carries out and document appropriate care * Reviews and updates job description annually * Adheres to dress code displaying a professional appearance * Establishes an effective working relationship with others * Reliable in following procedures/policies * Provides dental services to clients according to standards, program guidelines and collaborates with other health care disciplines. * Treats public with courtesy & respect * Maintains complete confidentiality of client information		
8. Accreditation process-development, implementation and maintenance.		

Employee's Signature: _____ Date_____

Supervisor's Signature:_____ Date_____

Employee's Signature: _____ Date_____

Supervisor's Signature:_____ Date_____

Employee's Signature: _____ Date_____

Supervisor's Signature:_____ Date_____

* When completed the employee needs to submit to dental office management support for filing.

* The Orientation Checklist should be completed at the end of the employee's probationary status.

Date Developed: 12/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 12/05; 6/19

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

DENTAL CLINIC MANAGEMENT SUPPORT ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A. Division of Public Health Services- 1. Mission, Vision, and Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B. Review of Policies: Agency – HIPAA-Policies & Procedures – Sign & Date 1. Agency Safety a. Fire Prevention and plan b. Smoke sensors c. Fire Extinguishers d. Exit Signs e. Security f. Tornado Plan g. Emergency Preparedness - Dental Clinic Disaster Training - Management Support Disaster Assistance - Emergency Shelters and Team Assigned - Review Dental Clinic Chart Retention & Release		
2. Personal Safety a. Agency Worksite b. Vehicle Safety c. Threatening Behavior d. Medical Emergencies - Clients - Employees - Staff training for: * HIPAA * Cultural Diversity * Infection Control		

3. Infection Control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and Handling Supplies g. Standard Precautions h. Blood borne Pathogens i. Vaccinations * TB Skin Test * Hepatitis B or Waiver * Rubella * Tetanus * Influenza * Varicella j. Equipment Management * Vaccine transporting * Handling & Storage k. Identifying, Handling and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment * Gloves * Impermeable Gown * Antibacterial Hand Wash * Spill Kit * N-95-Respirator Mask * Goggles/Face Shield		
4. Community Resources and Collaboration		
5. Continuing Education Requirements		
6. Employee Performance Evaluation		
C. Improving Organizational Performance Measures 1. IOP Committee and Purpose 2. Call supervisor 1 hour prior to start time if not reporting to work 3. Job Description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Audits c. Incident Reports d. Bloodbourne Pathogen Exposures e. Client Complaints		
D. Preceptor Assigned – works with and under Directions of preceptor		
E. Orientation Period – write in dates (one month)		

F. Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable) 4. Pager System 5. Scope of services and program policy review 6. Service/Program Record a. Documentation system b. Documentation of medical record data and encounter forms		
G. Dental Clinic Support Staff performance of duties: 1. Reviews expectations of the assigned role. 2. Reviews state, local agency guidelines for assigned role if applicable.		
H. Expectations of the Management Support Staff Role * Report to work-site as assigned in a timely manner * Use appropriate communication skills * Document and enter data appropriately * Accounts for all work hours through sign-out sheets, leave records, time sheets and mileage sheets. * Reviews and updates job description annually * Adheres to dress code– displaying a professional appearance or worksite appropriate attire * Provides management support services to clients according to standards, program guidelines and collaborates with other health department staff or community resources * Treats Public with courtesy, & respect * Maintains complete confidentiality of client information – where applicable.		

Comments:

_____

_____

_____

_____

*When completed the supervisor needs to submit to **Personnel Technician** for filing.

*The Orientation Checklist should be completed at the end of the employee's probationary status.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Date Developed: 12/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/19

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Dental Staff

Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Dental Staff applies theoretical concepts in practice.						
	B.	The Dental Staff work under direct supervisor of the dentist to assist with the following.						
	C.	The Dental Clinic Staff systematically collects data that is comprehensive and accurate.						
	D.	The Dental Clinic Staff observes, and records any reactions to treatment or changes in the client's condition.						
	E.	The Dental Clinic Staff intervenes to promote, maintain or restore health, to prevent illness, to minimize complications and effect rehabilitation.						
	F.	The Dental Clinic Staff evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	G.	The Dental Clinic Staff may participate in peer review and program audits to assure quality of services.						
	H.	The Dental Clinic Staff collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	I.	The Dental Clinic Staff reports to clinic as assigned in a timely manner.						
	J.	The Dental Clinic Staff introduces self to client.						
	K.	The Dental Clinic Staff uses appropriate communication techniques to make client comfortable, addresses client concerns and telephone calls with dignity and respect.						
	L.	The Dental Clinic Staff performs the work-up of clients, accurately documenting results of information obtained.						
	M.	Dental Clinic Staff facilitates the flow of clients through the clinic to promote health care accessibility, decrease wait time, and provide high quality services.						
	N.	Dental Clinic Staff demonstrates familiarity with the client record and chart composition.						
	O.	Dental Clinic Staff effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	P.	Dental Clinic Staff demonstrates support of agency by involvement in community activities.						
	Q.	Dental Clinic Staff uses chain of command for problem resolution.						
	R.	Dental Clinic Staff adheres to appropriate dress and grooming.						
	S.	Dental Clinic Staff maintains a reliable attendance record.						
	T.	Dental Clinic Staff safely and accurately assists other staff during procedures.						

	U.	The Dental Clinic Staff will thoroughly demonstrate assistance with: 1. Promotion and maintenance of health 2. Prevention of illness and disability 3. Diagnosing, treating and managing acute and chronic illnesses 4. Guidance and counseling for both individuals and families 5. Administering therapeutic measures, tests, procedures, drugs 6. Evaluating health outcomes 7. Quality Improvement for Dental Clinic Staff a. The Dental Clinic Staff will follow a written plan that has been devised by the dentist for evaluating the quality of care b. This plan will be documented identifying clinical problems, progress toward improving outcomes and recommendations for changes in treatment plan.						
	V.	Accurately records ICD-CDT Codes according to chief complaint and procedure performed.						
	W.	Accurately records daily client encounter.						
	X.	Documentation must be timely, accurate and precise.						
	Y.	Maintain licensure and continuing education requirements.						
	Z.	Adheres to agency policies and procedures - reviews annually						
	AA.	Reports any changes in client status.						
	BB.	Demonstrates ongoing communication with the client and professional staff.						
	CC.	Properly completes all required documentation on assigned clients within a timely manner using correct medical terminology.						
	DD.	Knowledgeable and maintains client rights and confidentiality.						
	EE.	Implements measures to maintain client confidentiality.						
	FF.	Demonstrates understanding and implementation of HIPAA compliance.						
	GG.	Provide empathic care for all clients including members of diverse and vulnerable populations						
	HH.	Apply the principles of jurisprudence to the practice of dentistry.						
	II.	Continuously analyze the outcomes of client treatment to improve that treatment						
	JJ.	Assess his or her level of skills and knowledge and take steps to improve areas of deficiency						
	KK.	Evaluate social and economic trends and their impact on oral health care						
	LL.	Assist with the activity of allied dental health						
	MM.	Maintain client records						
	NN.	Use business systems in dental practice settings for scheduling, recordkeeping, reimbursement, and financial arrangements.						
	OO.	Control infection with environmental safety programs according to current standards						
	PP.	Practice within the scope of one's competence and make referrals to professional colleagues.						
	QQ.	Use information technology and information management systems for client care, practice management, and professional development.						

	RR.	Assess client goals values and concerns to establish rapport and guide client care.								
	SS.	Communicate orally, and in writing, with peers, other professionals, staff, clients or guardians and the public at large.								
	TT.	Participate in improving the oral health of individuals, families, and groups in the community through diagnosis, treatment, and education.								
	UU.	Recognize predisposing and etiologic factors that require intervention to prevent disease.								
	VV.	Report of clinical findings and significant deviations that require monitoring treatment or management to the dentist,								
	WW.	Provide clinical radiographic and other diagnostic information and procedures								
	XX.	Obtain medical and dental consultations when appropriate with the dentist.								
	YY.	Educate clients so they can participate in the management of their own care.								
	ZZ.	Treatment plan that incorporates client's goals, values and concerns								
	AAA	Obtain informed consent from client, parent or guardian								
	BBB	Follow initial treatment and follow-up management for medical emergencies that may occur during dental treatment.								
	CCC	Perform basic cardiac life support								
	DDD	Recognize and manage acute pain, hemorrhage, trauma, and infection of the orofacial complex.								
	EEE	Manage client with pain and anxiety by the use of nonpharmacological methods.								
	FFF	Anticipate, prevent, and manage complications arising from the use of therapeutic and pharmacological agents employed in client care.								
	GGG	Provide client education to maximize oral health								
	HHH	Manage preventive oral health procedures								
	III	Assist with therapies to eliminate local etiology factors to control caries, periodontal disease, and other oral diseases								
	JJJ	Assist clients with advanced periodontal diseases and conditions								
	KKK	Assist clients with pulpal and periradicular diseases.								
	LLL	Assist with uncomplicated endodontic procedures								
	MMM.	Assist with uncomplicated oral surgical procedures								
	NNN	Assist clients who have complicated oral surgical problems								
	OOO	Assist clients requiring modification of oral tissues to optimize restorations of form, function and esthetics								
	PPP	Assist clients who have complex orthodontic problems								
	QQQ	Assist with restoring single defective teeth								
	RRR	Restore partial or completed edentulism with uncomplicated fixed or removable prosthetic restorations.								
	SSS	Manage the restoration of partial or complete edentulism using implant procedures								
	TTT	Assist client with oral esthetic needs								
II.	**Infection Control Measures:**									
		1.	**Handwashing** Washes hands at least 30 seconds under running water.							

		2.	Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.							
		3.	Keep fingers pointed down, lower than wrists to prevent contamination of the arms.							
		4.	Rinse hands under running water allowing water to flow from the upper arm down over the hands.							
		5.	Dry hands thoroughly with a dry paper towel.							
		6.	Use a separate paper towel to turn off the faucet.							
		7.	Use lotion to prevent drying of the skin.							
		8.	Cleanse hands with a 60% alcohol based hand sanitizer. Cover all surfaces of hands with product and rub until dry.							
	A.	Disposal of soiled materials								
	B.	Disposal of excretions								
	C.	Universal Precautions								
	D	Has attended initial training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.								
	E.	Demonstrates an understanding of and practices universal precautions.								
	F.	Demonstrates an understanding of modes of transmission of bloodborne diseases.								
	G.	Demonstrates knowledge and selection of personal protective equipment.								
	H.	Practices handwashing to prevent spread of disease.								
	I.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.								
			Standard Precautions							
		1.	Explain procedure							
		2.	Assemble equipment							
		3.	Wash hands							
		4.	Uses protective barrier precautions (mask, protective eyewear, gowns, gloves) as appropriate to prevent contact with client's body/blood fluids.							
		5.	Disposes of all needles/sharps in appropriate container. Fills sharps container only to 2/3 capacity.							
		6.	Secures lid on capacity filled container and places container on shelf in lab work-up room for disposal.							
		7.	Disposes of soiled material properly.							
		8.	Knows location of and usage for spill kit.							
		9.	Cleans equipment (stethoscope, blood pressure cuff) with alcohol wipe after each client usage. Cleans equipment weekly with Gavicide solution.							
		10.	Keeps one-way air resuscitation mask in emergency cart. Can demonstrate proper usage.							
III.	**Skills Performance:**									
	A.	Sitting:								
		1.	Position buttocks against the back of chair.							
		2.	Place feet flat on floor at 90 degree angle to lower legs.							
		3.	Flexes hip slightly so knees are higher than ischial tuberosities.							
		4.	Flexes lumbar spine slightly.							
		5.	Flexes elbows and places forearms on armrest, if applicable.							
	B.	Standing:								

		1.	Keeps feet parallel 6 inches to 8 inches apart.							
		2.	Places equal weight on both legs.							
		3.	Flexes knees slightly.							
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.							
	C.	Walking:								
		1.	Assumes the correct standing position.							
		2.	Steps forward a comfortable distance with one leg.							
		3.	Tilts the pelvis slightly forward and downward.							
		4.	Touches floor first with heel then ball of foot to toes.							
		5.	Advances the other arm and leg to promote balance.							
	D.	Pulling:								
		1.	Stands close to the object.							
		2.	Places one foot slightly ahead of the other.							
		3.	Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscle.							
	E.	Pushing:								
		1.	Places hands on object and flexes the elbows.							
		2.	Leans into the object by shifting weight from back leg to front leg.							
		3.	Applies smooth continuous pressure.							
	F.	Stooping:								
		1.	Stands with feet 10-13 inches apart.							
		2.	Places one foot slightly ahead of the other.							
		3.	Lowers self by flexing the knees.							
		4.	Places more weight on front foot than back.							
		5.	Keeps upper body straight (does not bend at the waist).							
		6.	Straightens knees keeping the back straight.							
	G.	Lifting and Carrying:								
		1.	Assumes stooping position directly in front of the object.							
		2.	Grasps object and tightens abdominal muscles.							
		3.	Stands up straight by straightening the knees.							
		4.	Carries the object close to the body waist high.							

_____ successfully demonstrates the above criteria in the clinical setting.

_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date

Developed: 12/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/19

The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Dentist

Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Dentist applies theoretical concepts in practice.						
	B.	The Dentist systematically collects data that is comprehensive and accurate.						
	C.	The Dentist observes, and records any reactions to treatment or changes in the client's condition.						
	D.	The Dentist intervenes to promote, maintain or restore health, to prevent illness, to minimize complications and effect rehabilitation.						
	E.	The Dentist evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	F.	The Dentist may participate in peer review and program audits to assure quality of services.						
	G.	The Dentist collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	H.	The Dentist reports to clinic as assigned in a timely manner.						
	I.	The Dentist introduces self to client.						
	J.	The Dentist uses appropriate communication techniques to make client comfortable, addresses client concerns and telephone calls with dignity and respect.						
	K.	The Dentist performs the work-up of clients, accurately documenting results of information obtained.						
	L.	Dentist facilitates the flow of clients through the clinic to promote health care accessibility, decrease wait time, and provide high quality services.						
	M.	Dentist demonstrates familiarity with the client record and chart composition.						
	N.	Dentist effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	O.	Dentist demonstrates support of agency by involvement in community activities.						
	P.	Dentist uses chain of command for problem resolution.						
	Q.	Dentist adheres to appropriate dress and grooming.						
	R.	Dentist maintains a reliable attendance record.						
	S.	Dentist safely and accurately assists other staff during procedures.						
	T.	The Dentist will thoroughly demonstrate: 1. Promotion and maintenance of health 2. Prevention of illness and disability 3. Diagnosing, treating and managing acute and chronic illnesses						

		4. Guidance and counseling for both individuals and families 5. Prescribing, administering and dispensing therapeutic measures, tests, procedures, drugs 6. Evaluating health outcomes 7. Quality Improvement for Dentist a. The Dentist will establish a written plan that for evaluating the quality of care b. This plan will be documented identifying clinical problems, progress toward improving outcomes and recommendations for changes in treatment plan.						
	U.	Accurately records ICD-CDT Codes according to chief complaint and procedure performed.						
	V.	Accurately records daily client encounter.						
	W.	Documentation must be timely, accurate and precise.						
	X.	Maintain licensure and continuing education requirements.						
	Y.	Adheres to agency policies and procedures - reviews annually						
	Z.	Reports any changes in client status.						
	AA.	Demonstrates ongoing communication with the client and professional staff.						
	BB.	Properly completes all required documentation on assigned clients within a timely manner using correct medical terminology.						
	CC.	Knowledgeable and maintains client rights and confidentiality.						
	DD.	Implements measures to maintain client confidentiality.						
	EE.	Demonstrates understanding and implementation of HIPAA compliance.						
	FF.	Apply ethical principles to professional practice.						
	GG.	Provide empathic care for all clients including members of diverse and vulnerable populations						
	HH.	Apply the principles of jurisprudence to the practice of dentistry						
	II.	Continuously analyze the outcomes of client treatment to improve that treatment						
	JJ.	Evaluate scientific literature and other sources of information to make decisions about dental treatment						
	KK.	Manage oral health based on an application of scientific principles						
	LL.	Participate in professional organizations						
	MM.	Assess his or her level of skill and knowledge and take steps to improve areas of deficiency						
	NN.	Evaluate social and economic trends and their impact on oral health care						
	OO.	Evaluate career options, practice locations and reimbursement mechanisms						
	PP.	Educate staff in professional, governmental, legal and office policies and professional responsibilities						
	QQ.	Coordinate and supervise the activity of allied dental health personnel						
	RR.	Maintain Client records						
	SS.	Use business systems in dental practice settings for scheduling, record keeping, reimbursement and financial arrangements.						
	TT.	Implement and monitor infection control and environmental safety programs according to current standards.						
	UU.	Practice within the scope of one's competence and make referrals to professional colleagues.						

	VV.	Use information technology and information management systems for client care, practice management and professional development.						
	WW.	Assess client goals, values, and concerns to establish rapport and guide client care.						
	XX.	Communicate orally, and in writing, with peers, other professionals, staff, client or guardians and the public at large						
	YY.	Participate in improving the oral health of individual families and groups in the community through diagnosis treatment and education.						
	ZZ.	Recognize predisposing and etiologic factors that require intervention to prevent disease						
	AAA.	Use clinical and epidemiological data to diagnose and establish a prognosis for dental abnormalities and pathology						
	BBB.	Recognize the normal range of clinical findings and significant deviations that require monitoring, treatment or management						
	CCC.	Monitor therapeutic outcomes and re-evaluate and modify initial diagnosis or therapy						
	DDD.	Develop treatment and alternatives based on clinical and supporting data						
	EEE.	Select, obtain, and interpret clinical , radiographic and other diagnostic information and procedures						
	FFF.	Obtain medical and dental consultations when appropriate						
	GGG.	Integrate multiple disciplines into an individual comprehensive sequenced treatment plan using diagnostic and prognostic information						
	HHH.	Discuss etiologies, treatment alternatives, and prognoses with clients and educate them so they can participate in the management of their own care						
	III.	Develop and implement a sequenced treatment plan that incorporates patient's goals, values and concerns						
	JJJ.	Obtain informed consent from client, parent or guardian						
	KKK.	Anticipate, diagnosis, and provide initial treatment and follow-up management for medical emergencies that may occur during dental treatment						
	LLL.	Perform basic cardiac life support						
	MMM	Recognize and manage acute pain, hemorrhage, trauma and infection of the orofacial complex						
	NNN.	Manage clients with pain and anxiety by the use of nonpharmacological methods						
	OOO.	Select and administer or prescribe pharmacological agent in the treatment of dental clients						
	PPP.	Anticipate prevent and manage complications arising from the use of therapeutic and pharmacological agents employed in client care.						
	QQQ.	Provide patient education to maximize oral health						
	RRR.	Manage preventive oral health procedures						
	SSS.	Perform therapies to eliminate local etiologic factors to control caries, periodontal disease, and other oral diseases						
	TTT.	Manage clients with advanced periodontal diseases and conditions						
	UUU.	Manage clients with pulpal and periradicular disease						
	VVV.	Perform uncomplicated endodontic procedures						
	WWW	Perform uncomplicated oral surgical procedures						
	XXX.	Manage clients who have complicated oral surgical problems						

	YYY.	Manage clients requiring modification of oral tissues to optimize restoration of form function and esthetics							
	ZZZ.	Manage clients with occlusal and temporomandibular disorders							
		Manage a comprehensive maintenance plan following the active phase of periodontal treatment							
		Manage clients requiring minor tooth movement or space maintenance							
		Manage clients who have complex orthodontic problems.							
		Restore single defective teeth							
		Restore partial or complete edentulism with uncomplicated fixed or removable prosthetic restorations							
		Manage the restoration of partial or complete edentulism using implant procedure.							
		Manage clients with oral esthetic needs							
		Communicate case design with laboratory technicians and evaluate the resultants prosthesis							
II.	**Infection Control Measures:**								
		Handwashing							
		1. Washes hands at least 30 seconds under running water.							
		2. Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.							
		3. Keep fingers pointed down, lower than wrists to prevent contamination of the arms.							
		4. Rinse hands under running water allowing water to flow from the upper arm down over the hands.							
		5. Dry hands thoroughly with a dry paper towel.							
		6. Use a separate paper towel to turn off the faucet.							
		7. Use lotion to prevent drying of the skin.							
		8. Cleanse hands with a 60% alcohol based hand sanitizer. Cover all surfaces of hands with product and rub until dry.							
	A.	Disposal of soiled materials							
	B.	Disposal of excretions							
	C.	Universal Precautions							
	D	Has attended initial training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.							
	E.	Demonstrates an understanding of and practices universal precautions.							
	F.	Demonstrates an understanding of modes of transmission of bloodborne diseases.							
	G.	Demonstrates knowledge and selection of personal protective equipment.							
	H.	Practices handwashing to prevent spread of disease.							
	I.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.							
		Standard Precautions							
		1. Explain procedure							
		2. Assemble equipment							
		3. Wash hands							
		4. Uses protective barrier precautions (mask, protective eyewear, gowns, gloves) as appropriate to prevent contact with client's body/blood fluids.							
		5. Disposes of all needles/sharps in appropriate container.							

		6.	Fills sharps container only to 2/3 capacity. Secures lid on capacity filled container and places container on shelf in lab work-up room for disposal.							
		7.	Disposes of soiled material properly.							
		8.	Knows location of and usage for spill kit.							
		9.	Cleans equipment (stethoscope, blood pressure cuff) with alcohol wipe after each client usage. Cleans equipment weekly with Gavicide solution.							
		10.	Keeps one-way air resuscitation mask in emergency cart. Can demonstrate proper usage.							
III.	**Skills Performance:**									
	A.		Sitting:							
		1.	Position buttocks against the back of chair.							
		2.	Place feet flat on floor at 90 degree angle to lower legs.							
		3.	Flexes hip slightly so knees are higher than ischial tuberosities.							
		4.	Flexes lumbar spine slightly.							
		5.	Flexes elbows and places forearms on armrest, if applicable.							
	B.		Standing:							
		1.	Keeps feet parallel 6 inches to 8 inches apart.							
		2.	Places equal weight on both legs.							
		3.	Flexes knees slightly.							
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.							
	C.		Walking:							
		1.	Assumes the correct standing position.							
		2.	Steps forward a comfortable distance with one leg.							
		3.	Tilts the pelvis slightly forward and downward.							
		4.	Touches floor first with heel then ball of foot to toes.							
		5.	Advances the other arm and leg to promote balance.							
	D.		Pulling:							
		1.	Stands close to the object.							
		2.	Places one foot slightly ahead of the other.							
		3.	Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttocks muscle.							
	E.		Pushing:							
		1.	Places hands on object and flexes the elbows.							
		2.	Leans into the object by shifting weight from back leg to front leg.							
		3.	Applies smooth continuous pressure.							
	F.		Stooping:							
		1.	Stands with feet 10-13 inches apart.							
		2.	Places one foot slightly ahead of the other.							
		3.	Lowers self by flexing the knees.							
		4.	Places more weight on front foot than back.							
		5.	Keeps upper body straight (does not bend at the waist).							
		6.	Straightens knees keeping the back straight.							
	G.		Lifting and Carrying:							
		1.	Assumes stooping position directly in front of the object.							
		2.	Grasps object and tightens abdominal muscles.							
		3.	Stands up straight by straightening the knees.							
		4.	Carries the object close to the body waist high.							

_____ successfully demonstrates the above criteria in the clinical setting.

_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date

Developed: 12/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/19

The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Dental Clinic Management Support Staff

Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Management Support Staff applies theoretical concepts in practice.						
	B.	The Management Support Staff systematically collects and completes data that is comprehensive and accurate.						
	C.	The Management Support Staff may assist in analyzing data about the community, family and individual.						
	D.	The Management Support Staff in collaboration with the Dental Staff strives to promote, maintain or restore health, to prevent illness, to minimize complications and effect rehabilitation.						
	E.	The Management Support Staff in collaboration with the Dental Staff evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	F.	The Management Support Staff may participate in peer review and program audits to assure quality of services.						
	G.	The Management Support Staff collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	H.	The Management Support Staff reports to work station as assigned in a timely manner.						
	I.	The Management Support Staff introduces self to client, when interacting with client services.						
	J.	The Management Support Staff uses appropriate communication techniques to make client comfortable, addresses client concerns and telephone calls with dignity and respect.						
	K.	The Management Support Staff may facilitate the flow of clients through the clinic to promote dental care accessibility decrease wait time and provide high quality services.						
	L.	Management Support Staff may demonstrate familiarity with the client record and chart composition.						
	M.	Management Support Staff effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	N.	Management Support Staff demonstrates support of agency by involvement in community activities.						
	O.	Management Support Staff uses chain of command for problem resolution.						
	P.	Management Support Staff adheres to appropriate dress and grooming.						

	Q.	Management Support Staff maintains a reliable attendance record.						
	R	Management Support Staff demonstrates competency in accurately filing of dental records.						
	S.	Management Support Staff demonstrates thorough knowledge of daily operation of the computer system.						
	T.	The Management Support Staff demonstrates accurate participation in their role of the billing cycle. 1. Data Entry for encounters 2. Data Entry /actual billing procedures						
	U.	Management Support Staff demonstrates thorough knowledge of typing skills, maintaining proficiency and timely manner.						
	V.	Management Support Staff demonstrates thorough knowledge of medical terminology and spelling.						
	W.	Management Support Staff demonstrates proficiency in general office procedures.						
	X.	Management Support Staff demonstrates ability to retrieve statistical information as needed.						
	Y.	Management Support Staff demonstrates thorough understanding of mail process and distribution services.						
	Z	Management Support Staff adheres to agencies policies and procedures – reviews annually.						
	AA.	Management Support Staff properly completes all required documentation on assigned clients within a timely manner using correct medical terminology.						
	BB.	Management Support Staff is knowledgeable and maintains client rights and confidentiality						
	CC.	Management Support Staff implements measures to maintain client confidentiality.						
	DD.	Management Support Staff demonstrates understanding and implementation of HIPAA compliance.						
II.		**Infection Control Measures:**						
		Hand washing 1. Washes hands at least 30 seconds under running water. 2. Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap. 3. Keep fingers pointed down; lower than wrists to prevent contamination of the arms. 4. Rinse hands under running water allowing water to flow from the upper arm down over the hands. 5. Dry hands thoroughly with a dry paper towel. 6. Use a separate paper towel to turn off the faucet. 7. Use lotion to prevent drying of the skin. 8. Cleanse hands with a 60% alcohol based hand sanitizer. Cover all surfaces of hands with product and rub until dry.						
	A.	Disposal of soiled materials						
	B.	Disposal of excretions						
	C.	Universal Precautions						
	D	Has attended annual training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.						
	E.	Demonstrates an understanding of and practices universal precautions.						

	F.	Demonstrates an understanding of modes of transmission of blood borne diseases.							
	G.	Demonstrates knowledge and selection of personal protective equipment.							
	H.	Practices hand washing to prevent spread of disease.							
	I.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.							
		Standard Precautions							
		1. Assemble equipment							
		2. Wash hands							
		3. Uses protective barrier precautions (mask, protective eyewear, gowns, and gloves) as appropriate to prevent contact with client's body/blood fluids.							
		4. Disposes of all needles/sharps in appropriate container. Fills sharps container only to 2/3 capacity.							
		5. Secures lid on capacity filled container and places container on shelf in lab work-up room for disposal.							
		6. Disposes of soiled linen properly.							
		7. Knows location of and usage for spill kit. Nursing home visiting staff keeps spill kit in their car.							
III.	**Skills Performance:**								
	A.	Sitting:							
		1. Position buttocks against the back of chair.							
		2. Place feet flat on floor at 90 degree angle to lower legs.							
		3. Flexes hip slightly so knees are higher than ischial tuberosities.							
		4. Flexes lumbar spine slightly.							
		5. Flexes elbows and places forearms on armrest, if applicable.							
	B.	Standing:							
		1. Keeps feet parallel 6 inches to 8 inches apart.							
		2. Places equal weight on both legs.							
		3. Flexes knees slightly.							
		4. Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.							
	C.	Walking:							
		1. Assumes the correct standing position.							
		2. Steps forward a comfortable distance with one leg.							
		3. Tilts the pelvis slightly forward and downward.							
		4. Touches floor first with heel then ball of foot to toes.							
		5. Advances the other arm and leg to promote balance.							
	D.	Pulling:							
		1. Stands close to the object.							
		2. Places one foot slightly ahead of the other.							
		3. Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscle.							
	E.	Pushing:							
		1. Places hands on object and flexes the elbows.							
		2. Leans into the object by shifting weight from back leg to front leg.							
		3. Applies smooth continuous pressure.							
	F.	Stooping:							
		1. Stands with feet 10-13 inches apart.							

		2.	Places one foot slightly ahead of the other.							
		3.	Lowers self by flexing the knees.							
		4.	Places more weight on front foot than back.							
		5.	Keeps upper body straight (does not bend at the waist).							
		6.	Straightens knees keeping the back straight.							
	G.	Lifting and Carrying:								
		1.	Assumes stooping position directly in front of the object.							
		2.	Grasps object and tightens abdominal muscles.							
		3.	Stands up straight by straightening the knees.							
		4.	Carries the object close to the body waist high.							

_____ successfully demonstrates the above criteria in the work setting.

_____ _____

Employee Signature & Date Reviewer's Initials & Date

_____ _____

Employee Signature & Date Reviewer's Initials & Date

_____ _____

Employee Signature & Date Reviewer's Initials & Date

Developed: 12/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/19

Rev/di

ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF PUBLIC HEALTH SERVICES

ENVIRONMENTAL HEALTH PROGRAM POLICIES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ENVIRONMENTAL HEALTH PROGRAM

DATE DEVELOPED: 10/05
REVIEWED: 6/17; 6/18; 8/18; 6/19; 6/20; 6/21; 6/22; 6/23; 2/24; 6/24
REVISED: 6/17; 6/18; 8/18; 6/19; 6/20; 6/22; 6/23; 2/24

I. POLICY:

The Environmental Health Program will provide services to **onsite** septic systems in areas with suitable soil; protect water supplies and well heads; ensure proper sanitation of food establishments, lodging, and institutions; assist with the Animal Shelter's rabies clinics and education; inspect manufactured home parks and migrant labor facilities; participate in communicable disease investigations; and provide assistance to agencies involved with emergency situations.

II. PURPOSE:

The goal of the Environmental Health Program is to prevent communicable and environmentally-related diseases in Rockingham County so that citizens will have a clean and healthy environment, safe food, water, and air.

III. GUIDELINES:

A. Eligibility: Services are provided to members of the public who utilize Rockingham County's food establishments, lodging facilities, and institutions. A fee is charged for conducting a plan review for anyone who applies for a new facility or change of ownership. The public may apply and submit a fee for **onsite** wastewater and **private drinking water** well evaluations.

B. The following services are provided: Septic system evaluations, permitting and inspections by applications and fees; well site evaluations, permitting and inspections by applications and fees; existing well inspections and water supply sampling by applications and fees; public swimming pool inspections and water supply sampling by applications and fees; tattoo artist inspections by applications and fees; migrant labor facilities by applications. Some services are provided for public health significance – without fees and applications. They are: lead investigations, complaint response, potential rabies case consultations, manufactured home park inspections, air quality consultations for regulated facilities, emergency assistance, sanitation inspections of food establishments, lodging establishments, institutions, child care centers and school buildings. Environmental Health assists the nursing staff in the investigation of communicable disease outbreaks, including foodborne and waterborne illnesses. Citizens may request services by telephone, e-mail, letters, and visits to the Environmental Health offices.

C. Hours of Operation:

Environmental Health Services are available Monday-Friday from 8:00 a.m. to 5:00 p.m. The best way to contact the Environmental Health Staff is by telephone, **email,** or by appointment between 8:00 a.m. and 9:00 a.m. Monday through Friday.

D. Guides, Regulations, Policies and References Used by Employees:

1. State regulations, laws and rules: **15A NCAC 18E** Sewage Treatment and Disposal Systems; 15A NCAC 2C .0100 Well Construction Rules; 15A NCAC 2C .0300 Permitting and Inspection of Private Drinking Water Wells; 15A NCAC 18A .3800 Private Drinking Water Well Sampling Rules; 15A NCAC 18A .1000 Rules Governing the Sanitation of Summer Camps; 15A NCAC 18A .1300 Rules Governing Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions; 15A NCAC 18A .1500 Rules Governing Sanitation of Local Confinement Facilities; 15A NCAC 18A.1600 Rules Governing Sanitation of Residential Care Facilities;15A NCAC 18A .1700 Rules Governing Protection of Water Supplies; 15A NCAC 18A .1800 Rules Governing Sanitation of Lodging Establishments; 15A NCAC18A .2400 Rules Governing Sanitation of Public, Private and Religious Schools; 15A NCAC 18A .2500 Rules Governing Public Swimming Pools; 15A NCAC 18A .2600 Rules Governing Food Protection and Sanitation of Food Establishments; North Carolina Food Code Manual; 15A NCAC 18A .2800 Rules Governing Sanitation of Child Care Centers; 15A NCAC 18A .3100 Rules Governing Lead Poisoning Prevention in Children Program; 15A NCAC 18A .3200 Rules Governing Tattooing; 15A NCAC 18A .3300 Rules Governing the Sanitation of Adult Day Service Facilities; 15A NCAC 18A .3500 Rules Governing the Sanitation of Primitive Camps; 15A NCAC 18A .3600 Rules Governing Sanitation of Resident Camps; **15A NCAC 18A.2100 Rules Governing the Sanitation and Safety of Migrant Housing;** North Carolina Public Health Law G.S. 130A.

2. Local Ordinances and Rules: Rules Governing the Sanitary Design, Construction, Alteration, Maintenance, Operation and Use of Manufactured Home Parks in Rockingham County, North Carolina; Rockingham County Animal Control Ordinance and Amendment to the Animal Control Ordinance.

3. Rockingham County Ordinances can be accessed at https://www.co.rockingham.nc.us and North Carolina laws and rules governing sanitation may be accessed at: http://ehs.ncpublichealth.com/rules.htm.

4. In addition to the rules and regulations that the Specialist must master and/or be familiar with in order to perform at the minimum competency level for this position, the Specialist should have a working knowledge of other county rules and regulations including planning and zoning rules. The Specialist is not responsible for enforcing these rules, but these rules often have a direct bearing on the issuance of septic system permits, including the placement of nitrification lines **and private drinking water** wells.

E. Staff Credentials and Qualifications:

1. An Environmental Health Specialist Intern (EHSI) **hired after 10/1/23 must follow the table below:**

Registrant Type	Minimum/Maximum Intern
Registrants with Environmental Health Degrees	**Minimum: 0 years** **Maximum: 2 years**
Registrants with Public Health Degrees	**Minimum: 1 year** **Maximum: 2 years**
Registrants with Non-Environmental Health Degree or Public Health Degrees	**Minimum: 1 year** **Maximum: 2 years**

2. An EHSI **must meet any of the following combinations of education and practice experience standards:**

a. Graduated with a bachelor's degree or postgraduate degree from a program that is accredited by the National Environmental Health Science and Protection Accreditation Council.

b. Graduated with a bachelor's degree or postgraduate degree and:

i. Earned a minimum of 30 semester hours or 45 quarter hours in the physical, biological, natural, life, or health sciences; and

ii. Has one or more years of experience in the field of environmental health practice.

c. Graduated with a bachelor's degree or postgraduate degree in public health and has one or more years of experience in the field of environmental health practice.

3. Environmental Health Specialist Interns must attend Centralized Intern Training and complete the required field practice along with the proper documentation for field practice. Once all required training and field practice is completed, the EHSI applies for Delegation of Authority to enforce state rules and laws that require an Authorization from a State Regional Environmental

Health Specialist. There are currently eight areas for which enforcement authority can be granted after completion of specifically related training. Specialists can be authorized in one or as many areas as needed. The eight areas of authorization are: Child-Care & School Sanitation (CCSS), Childhood Lead Poisoning Prevention (CLPP), Food Lodging and Institutions (FLI), Migrant Housing (MH), On-Site Wastewater (OSWW), Public Swimming Pools (PSP), Tattoos (TATT) and Private Wells (Wells).

F. Staff Continuing Education Requirements:

Each Environmental Health Specialist must complete 15 hours of continuing education per calendar year.

G. Quality Assurance:

1. Monthly reports of wastewater activities are prepared to indicate the number of site evaluations conducted, number of well and septic permits issued or denied, and Operation Permits issued. These reports include new and repair permits. The reports are e-mailed to the On-Site Wastewater Section of the **Environmental Health Branch** of the Department of Health and Human Services in Raleigh at the beginning of each new month. Food Establishment inspections and the facilities inspected are electronically uploaded to the Inspections, Statistics and Fees Program in the Department of Health and Human Services in Raleigh via CDP. The On-Site Wastewater Program Improvement Team, including the Regional Soil Scientist, visits to survey and review the On-Site Wastewater Program in Rockingham County upon notice to the local program or by request. The Regional Environmental Health Specialist for Food Establishment, Lodging and Institutional inspections, **for Children's Environmental Health, and for Pools and Tattoos** visits to survey and review this program upon notice to the local program or by request.

2. Quality Assurance is provided by the Environmental Health Programs Coordinators. Staff performance is evaluated by field review with Environmental Health Specialists at inspection sites and by review conferences, meeting workload demands, by review of permits issued, and review of food establishment, lodging and institutional inspection reports.

3. Satisfaction Surveys are a survey link emailed to clients who apply for On-Site Wastewater, Well and Water Sample services. Satisfaction Surveys are also given to food service establishments and institutional operations and to persons who apply for restaurant and institutional plan reviews. The results of the Satisfaction

Surveys will be disseminated among staff for feedback and to the Board of Health and Human Services.

4. If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EVALUATION FOR ONSITE SEWAGE TREATMENT/DISPOSAL

DATE DEVELOPED: 11/9
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 2/24; 6/24
REVISED: 6/17; 6/18; 6/21; 6/23; 2/24; 6/24

I. POLICY:

Once a complete application has been submitted for a site, a site evaluation will be conducted in accordance with the "Laws and Rules for Sewage Treatment and Disposal Systems: (15A NCAC **18E**) to determine the suitability to adequately treat and dispose of sewage effluent.

II. PURPOSE:

A. To prevent the spread of communicable diseases and protect the environment from the failure of subsurface sewage treatment and disposal systems.

B. Article 11 of G.S. 130A-333-345 governs Wastewater Systems. The Rockingham County Environmental Health Section follows these laws, rules, and the SCOPE defined in 15A NCAC **18E:0101**: The rules contained in this Section shall govern the treatment and disposal of domestic **strength** sewage from septic tank systems, privies, incinerating toilets, mechanical toilets, composting toilets, recycling toilets, or other such systems serving single or multiple-family residences, places of business, or places of public assembly, the effluent from which is designed not to discharge to the land surface or surface waters.

1. According to 15A NCAC **18E.0302 (a) The permitting of a wastewater system** shall be the responsibility of agents authorized by the **Department** in accordance with G.S. 130A**, Article 4 and 15A NCAC 01O.0100,** and registered with the State of North Carolina Board of Environmental Health Specialist Examiners as required in G.S. 90A Article 4, **unless the permit is issued in accordance with G.S. 130A-336.1 or 130A-336.2 and Rule 15A NCAC 18E.0207**. Records are kept, as required by the **Records Retention and Disposition Schedule for Local Health Departments, Standard 15, Items 9-14.**

2. Complaints involving wastewater systems will be investigated, according to Environmental Health Complaint and Enforcement Policy (EH-29). Corrective actions shall be taken in cases of valid complaints according to 15A NCAC **18E.1306.**

III. GUIDELINES:

A. An application shall be submitted for the evaluation of a site or sites in accordance with **15A NCAC 18E.0202.**

B. The applicant shall pay all required fees and furnish the required information including a complete site plan **as required by 15A NCAC 18E.0202**.

The applicant shall be responsible for properly identifying **at the site**:

1) All applicable property lines
2) Location of proposed structures
3) Any easements or rights-of-way
4) Buried tanks
5) Buried wiring
6) Buried cable
7) Buried water lines
8) Buried sewer line
9) Buried solid waste
10) Any other items deemed necessary

C. The Environmental Health Section will conduct site evaluations on lots in a timely manner once the applicant has completed all requirements.

1. Requests for evaluation of three (3) or less sites may be evaluated by an Environmental Health Specialist. Backhoe pits may be required under Rule **.0501(d).**

2. Requests for site evaluations of four (4) or more lots may be assigned to the OSWW Program Coordinator or to an Environmental Health Specialist. The applicant of four (4) or more lots shall supply the local health department with a plat or survey of the lots with house locations to scale on each lot. The house location shall be flagged on each lot as indicated on the plat or survey submitted. Backhoe pits are required for four (4) or more lots.

3. Backhoe pits may be required under Rule **.0501(d)**. If required, arrangements for the backhoe to be present during the site evaluation will be the sole responsibility of the applicant. The applicant must contact the assigned staff member on a business day to schedule the evaluation.

4. Soil profiles will be conducted on each individual lot with:

a. Sufficient auger borings or backhoe excavations are done to cover the areas where an initial subsurface disposal field and repair area are to be located.

i. For Improvement Permits, a minimum of 3 borings is required.
ii. For Construction Authorization Permits, at least one confirmation boring is required if more than 30 days has passed since the initial site evaluation or if the initial site evaluation was done by another Environmental Health staff member.

b. The soil profile for each boring is documented in ArcGIS Field Maps or on a Site Evaluation Factors Chart for Improvement Permit/Construction Authorization form.

c. An Improvement Permit and/or Construction Authorization Permit may be issued for each lot after the soil borings and documentation have been completed to show that each lot has suitable soil and space for the installation of an initial subsurface disposal field and repair area.

5. In the case of an application to repair an existing subsurface wastewater system:

a. Sufficient soil borings are done and documented where the repair system is to be located.

b. The soil profile for each boring is documented in ArcGIS Field Maps or on a Site Evaluation Factors Chart for Improvement Permit/Construction Authorization form.

c. Soil profiles are evaluated at the site by borings to at least 48 inches or to an unsuitable characteristic, and a determination is made as to the suitability of the soil to treat and absorb septic tank effluent.

d. The **owner of the system may request, on a form provided by the Department, that the** Environmental Health Specialist use best professional judgment **according to 15A NCAC 18E.1306(c)(2)** in requiring repairs that will reasonably enable the system to function properly.

D. Appeals

1. A site evaluation for a second opinion may be conducted by the OSWW Program Coordinator upon request from the applicant, owner and/or agent.

- If required by Rule .**0501(d),** arrangements for the backhoe to be present during the soil/site evaluation will be the sole responsibility of the applicant.

2. If the site is denied by the OSWW Program Coordinator, the applicant, owner and/or agent will be notified of their right to request an informal appeal to the state Regional Soil Scientist.

    - If required by Rule **.0501(d)**, arrangements for the backhoe to be present during the soil/site evaluation will be the sole responsibility of the applicant.

3. If the site is denied by the state Regional Soil Scientist, the applicant, owner and/or agent will be notified of their right to appeal to the North Carolina Office of Administrative Hearings.

4. If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: APPLICATION PROCEDURES

DATE DEVELOPED: 02/04
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 2/24; 6/24
REVISED: 6/17; 6/19; 6/23; 2/24

I. POLICY:

Applications for onsite wastewater and private drinking water well services must be made to the Central Permitting Office.

II. PURPOSE:

To assure that all Environmental Health regulations are followed.

III. GUIDELINES:

A. Applications are taken by the Central Permit Technician.

1. In accordance with State Law, applicants are required to provide a site plan consistent with 15A NCAC **18E.0202** and 15A NCAC 02C.0300 rules.

2. The following questions are asked of each applicant (See EH-3 Example Site Plan):

   a. Where will the residence or structure be constructed on the property?
   b. How far from at least two property lines (or proposed property lines) will the proposed structure be located?
   c. What are the dimensions of the proposed structure?
   d. Is there any existing well or septic system on the property or on adjoining properties that are within 100' of their property lines?
   e. Are the applicants planning any future additions such as a pool, deck, storage building, etc.?
   f. Are there any underground utility lines such as buried cable, power or telephone lines?
   g. Are there any easements, right-of-ways, creeks, rivers, ponds, buried sewage lines and water lines?
   h. If applying for a septic check of an existing septic system or modification of an existing septic system for a residence, how many bedrooms were in the original home?

3. When applying for a Construction Authorization and/or Well Permits, applicants are asked if there are any changes from the initial Improvement Permit. If there are no changes, the applicant will sign and date a copy of the initial Improvement Permit diagram. If there are any changes from the initial Improvement Permit, the applicant will provide a new site plan.

B. Applicants must read and sign the checklist for marking property (See EH-3 Checklist for Marking Property) which provides instructions for flagging and marking the property corners and lines, underground utility lines and the foot print of any proposed structures. Applicants are given a copy of the checklist along with a site card when the application process is completed.

Rev/di

CHECKLIST FOR MARKING PROPERTY

The following steps must be completed before your application will be accepted:

- ○ Each **property corner** or proposed property corners **MUST** be clearly marked using stakes, ribbons or flagging
- ○ Each **property line** or proposed property line **MUST** be clearly marked using stakes, ribbons or flagging
- ○ When property has **heavy or thick undergrowth**, site will need to be **cleared** before an evaluation will be conducted
- ○ Outermost corners of **proposed building(s)** **MUST** be marked with stakes, ribbons or flags so that **entire footprint** of the building is identifiable
- ○ All **underground lines** marked by calling the One-Call center at **811** (no charge for this service)
- ○ Place **orange site card** so that it is visible at road frontage of your property

If **any** of the required steps have **NOT** been completed at time of evaluation, I understand that I will be charged a **$100 revisit fee** **BEFORE** the evaluation will be completed.

I verify that I have completed all of the required steps of properly marking my property for site evaluation.

_____ _____

Applicant Signature **Date**

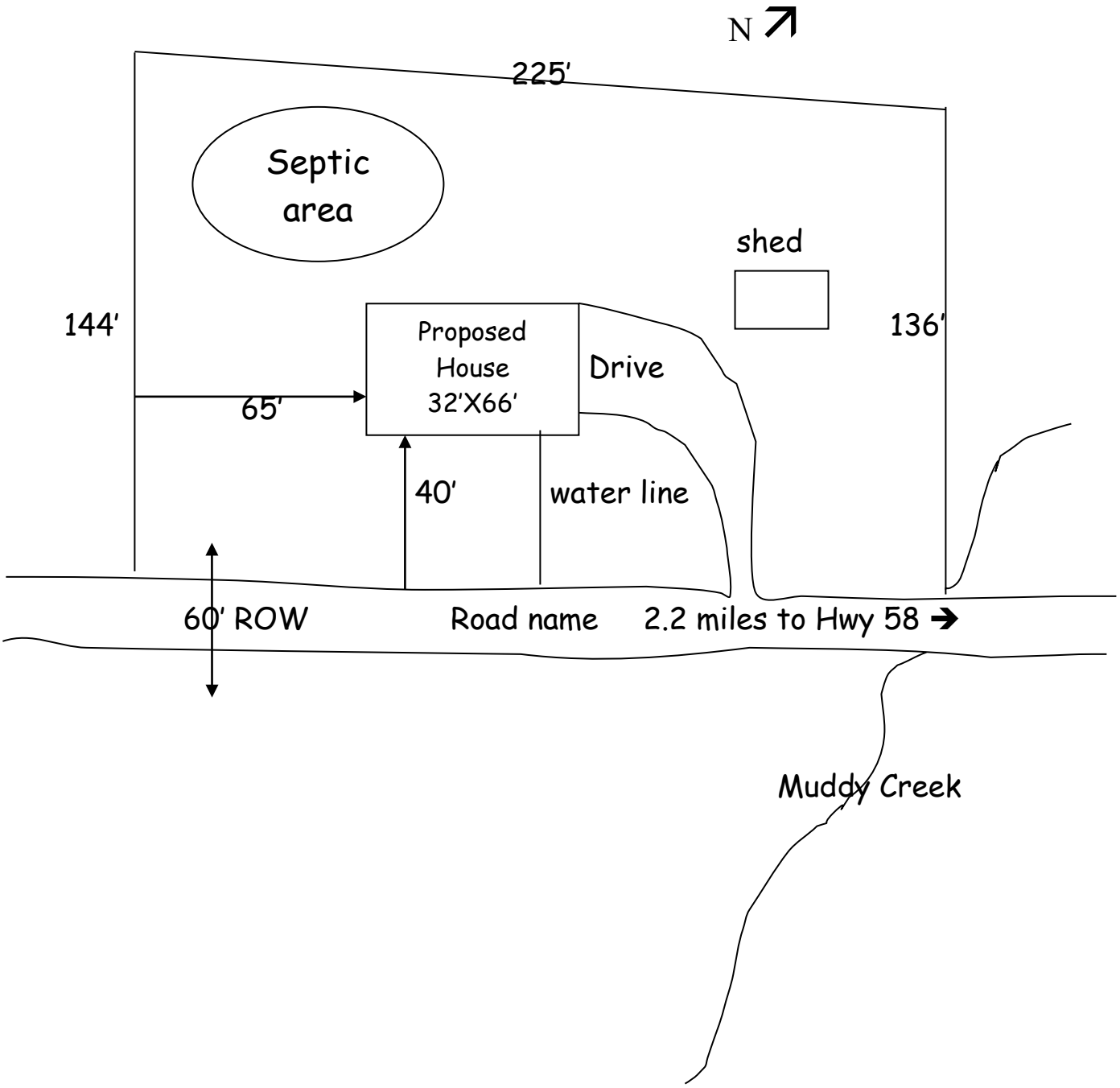
CHECKLIST FOR ALL SITE PLANS

- ○ **All property lines and/or proposed property lines**
- ○ **Roads/streets in relationship to property**
- ○ **HOUSE/BUILDING** location **MUST** have:
  a. **Dimensions of house/building including decks/porches**
  b. **Distance from house/building to 2 property lines**
- ○ Location of **all proposed driveways**
- ○ Location of any **existing wells and/or septic systems on or within 100 feet of property**
- ○ Location of any **buried utility lines such as cable, power, telephone, water, sewage or gas lines**
- ○ Location of **any underground tanks**
- ○ Location of **any easements or right-of-ways**
- ○ Location of any **surface bodies of water, such as creeks, ponds or rivers**
- ○ Location of **any proposed future additions, such as swimming pools, storage buildings, garages, etc.**

*** See reverse for example***

Example Site Plan

This example was prepared to assist you in drawing your own site plan. Without your site plan we cannot perform the site evaluation. If you have any questions, please call us at (336)342-8180



ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ENVIRONMENTAL HEALTH SERVICES PRIORITIZATION

DATE DEVELOPED: 6/22
REVIEWED: 6/22; 6/23; 6/24
REVISED:

I. POLICY:

Rockingham County Environmental Health will prioritize the frequency of Food and Lodging inspections in the event of a staffing shortage.

II. PURPOSE:

This policy provides instruction on how to prioritize the frequency of Food and Lodging inspections. The Rockingham County Environmental Health program will utilize this policy to maintain the statewide inspection prioritization standard.

III. GUIDELINES:

A. Definitions:

1. Risk Frequency means the minimum number of inspections to be performed in the required time allotment of a fiscal year as stated in Rule 10A NCAC 46.0213. Risk Frequency takes into consideration population served, specialized food processes, handling of raw foods, and any multi-step/stage cooking and cooling methods.

2. Highly Susceptible Population (HSP) means persons who are more likely than other people in the general population to experience foodborne disease because they are: (1) immunocompromised; preschool age children, or older adults; and (2) obtaining food at a facility that provides services such as custodial care, health care, or assisted living, such as a child or adult day care center, kidney dialysis center, hospital or nursing home, or nutritional/socialization services such as a senior center.

B. Responsibilities:

1. The Environmental Health Supervisor, or their designee, will be responsible for assigning work priorities to assure inspections are made using the procedures/criteria set forth in this policy.

C. Procedures:

1. The following procedures shall be used in assigning a risk frequency of inspection to a facility:

   a. The Registered Environmental Health Specialist (REHS) shall perform a menu review/review of food handling procedures during a routine sanitation inspection.
   b. Observations of food processes that may be considered a specialized process and would require a variance from the NC Variance Committee should be documented either on a Comment Addendum and/or a Food Establishment Inspection Form. Any food service facility that performs a specialized process that requires the use of a variance shall automatically be inspected as a category IV facility.
   c. The REHS shall use the Risk Categorization of Food Establishment Flow Chart, provided by the NC Department of Health and Human Services Environmental Health Section, to assess food handling processes and assign the correct risk category.

2. The following procedures shall be implemented to assure that inspections are prioritized by a risk-based approach *(Factors, such as risk factor violations documented on previous inspections, length of time since completion of last inspection, and frequency of complaints from the public, shall be taken into consideration when determining the priority of inspections. Facilities of higher risk frequency or history of non-compliance should take priority over those of lower risk frequency or better compliance.)*

   a. All category IV establishments, conducting a specialized food process or serving HSPs, shall be inspected at 100% compliance.
   b. All other establishments shall miss no more than one grading period per fiscal year with category IV establishments taking priority over all other establishment categories. In cases where missing only one inspection per FY is not possible, category IV establishments shall still be inspected at higher frequencies than other categories. *Ex: Category IV establishments shall be inspected 3X/year in lieu of category III, II, or I establishments inspected at 100% compliance.*

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: UTILIZATION OF AUGERS AND PROBES IN AREAS WITH BURIED UTILITY LINES

DATE DEVELOPED: 1/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18; 6/23

I. POLICY:

Environmental Health staff will not, under any circumstances, use augers or probes in areas where there might be buried utility lines.

II. PURPOSE:

The purpose of this policy is to prevent injuries to employees and to reduce the liability of the Agency and property owners who have buried utility lines on their property.

III. GUIDELINES:

A. Augers are used for soil evaluation at various depths.

B. Probes are routinely used to locate septic systems.

C. The homeowner is responsible for contacting utility companies to locate and flag utility lines prior to the use of augers or probes. Where field observations deem it necessary for wastewater system repairs, the property owner must call the North Carolina One-Call Center, 811, to locate all underground utility lines prior to the Environmental Health on-site investigation or evaluation. If an employee is in an area where there is a strong likelihood of buried underground utility lines that have not been flagged or identified, he/she is to remind the homeowner of his/her responsibility to contact utility companies before an evaluation will proceed. The Environmental Health Specialist will return when all underground utilities have been identified.

D. As described in G.S. 87-113 (a), any person who does an excavation (including an auger boring or soil probing evaluation) that results in known damage to an underground utility – shall, immediately after discovery of the damage, notify the utility owner of the location and type of damage. The utility owner must be allowed reasonable time to repair the damage before the excavation is completed in the immediate area of the damaged underground utility.

E. According to G.S. 87-113 (b), "The person responsible for conducting any excavation that results in damage to an underground utility where the damage may endanger life, health, or property shall, immediately after discovery of the damage, take action to protect the public and property, notify the utility owner, notify the police or fire departments, and take any other actions to minimize the hazards until the arrival of the utility owner's personnel, the police, or the fire department." Any filling in of soil or backfilling in the immediate area of the damaged underground utility must be delayed until authorized by the utility owner, unless it is necessary to prevent injury or property damage to other. Repair of any damage is to be performed by the utility owner or by qualified personnel authorized by the utility owner.

F. While the agency's probes have insulated handles certified to 50,000 volts, the probe *is not to be used* in areas suspected of having underground utility lines.

G. The agency has purchased Auger handles with rubber coating. These handles are for user comfort only and are not rated for any protection from electrical shock.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: FIELD SAFETY AND FIELD SAFETY EQUIPMENT

DATE DEVELOPED: 1/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 3/09

I. POLICY:

Environmental Health staff shall utilize and maintain field safety equipment appropriately.

II. PURPOSE:

To avoid preventable injuries to employees by appropriately using and maintaining field safety equipment and complying with OSHA regulations.

III. GUIDELINES:

A. When it is necessary to wear a hard hat, employees must wear hard hats that meet the following OSHA specifications for Class A (reclassified as Class G under ANSIZ89.1-1997) protection against impact and falling objects.

- ANSIZ89.1-1986 if purchased after July 5, 1994

B. Employees may not drill holes in hard hats or scribe initials in them.

C. Hard hats may not be cleaned with solvents.

D. Clearance between the head and hat crown must be at least 1.25 inches.

E. Hard hats must be properly maintained.

F. Hard hats must not be worn backwards.

G. Hard hats are provided for employee personal protection and must be worn when an employee is on a site where overhead hazards exist. Overhead hazards could be the result of construction/repair work overhead, moving objects overhead, or objects suspended from overhead that an employee could bump into.

H. Safety glasses are provided for employees' eye protection and must be worn any time an employee is on a site where eye hazards exist.

I. The preferred footwear for Environmental Health employees working in the field is steel-toed boots, but the final decision is at the employee's discretion.

J. Environmental Health staff shall not enter a trench that is more than 48" deep.

K. Environmental Health staff should take necessary precautions when working in areas with a potential of having poisonous/hazardous vegetation (ex. Poison Oak/Ivy and Briars) and/or insects that bite/sting. Precautions may include the wearing of appropriate protective clothing and approved skin barriers.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EXISTING SYSTEM APPROVALS FOR RECONNECTIONS/ PROPERTY ADDITIONS AND SYSTEM MALFUNCTION AND REPAIR

DATE DEVELOPED: 6/93
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 2/24; 6/24
REVISED: 6/18; 6/20; 6/23; 2/24; 6/24

I. POLICY

This policy is a guide to provide general suggestions to evaluate existing septic tank systems and for addressing malfunctioning wastewater systems. The Environmental Health Section reserves the right to make changes in content or application of its policies, as it deems appropriate. These changes may be implemented, even if they have not been printed in this policy.

II. PURPOSE:

To provide the Environmental Health Section with the procedural guidelines directing the proper course of action for repair of malfunctioning wastewater systems as described in: WASTE WATER SYSTEMS - ARTICLE 11, CHAPTER 130A OF NORTH CAROLINA GENERAL STATUTES 130A-333-343 and 15A NCAC **18E** SEWAGE TREATMENT AND DISPOSAL SYSTEMS.

III. GUIDELINES:

1. The Environmental Health Section will conduct an evaluation of an existing septic system to reconnect to a system. The purpose of this evaluation is to note septic tank system setbacks on the date of the inspection. The evaluation does not certify compliance with Article 11 G.S. 130A. The history of the sewage system should be thoroughly reviewed by the applicant along with his/her responsibilities and those of the Certified On-site Wastewater Contractor or Inspector. The following procedures are followed by the Environmental Health Specialist while conducting an evaluation of an existing septic system:

    a. A review of the property file is conducted to determine if an Operation Permit or Certificate of Completion exists for the system.

    b. The property is visited by the Environmental Health Specialist and the premises inspected for any evidence of a septic system malfunction. The specialist also inspects the premises to determine if any visible sewage discharges or sewage discharge pipes are present. If possible, the Environmental Health Specialist uses a metal probe rod **and/or Ground Penetrating Radar to locate** the septic tank and location of the drainfield.

c. Any problems noted regarding the septic system are communicated with the property owner and the applicant. The property owner shall be responsible for compliance with **15A NCAC 18E.0206.**

d. The Specialist will verify that the existing **septic system complies with its Operation Permit or the system was in use prior to July 1, 1977; there is no current or past uncorrected malfunction, the flow and wastewater strength for the proposed facility does not exceed that of the existing system; and the facility meets the setbacks in 15A NCAC 18E.0600.** Upon verification, the Specialist issues **a written approval to connect the new facility** to the existing system. **A building permit for this approved facility must be issued within 90 days of the approval.**

e. **According to 15A NCAC 18E.0206, prior to the relocation of a structure or the expansion of an existing facility's foot print that requires the issuance of a building permit, but does not increase the flow or wastewater strength, the specialist shall issue an approval upon determination of the compliance of the proposed structure with setback requirements in 15A NCAC 18E.0600. If an approval cannot be issued, a signed, written letter shall be provided to the applicant describing the reason for the denial and notice of the right to appeal under G.S. 130A-24 and 150B.**

3. When the Environmental Health Section becomes aware of a malfunctioning wastewater system, a Specialist will locate, identify and document the malfunctioning wastewater system [as defined in the North Carolina G.S. 130A-336A-336(a), (b) and **Rule .1303**].

4. After confirming a violation, the **Environmental Health Specialist shall issue a written Notice of Violation (NOV) to the wastewater system owner in accordance with 15A NCAC 18E.0302(c).**

5. The written NOV shall contain the following information:

   a. Name of responsible person
   b. Address of violation
   c. Date
   d. Citation to which rule/statute and section was violated
   e. Description of violation
   f. Steps necessary for correction of violation
   g. Timeline for fixing violation

6. Within thirty (30) days of written NOV, the **property** owner shall obtain a repair application G.S. 130A-336(b)**,** and complete repairs pursuant to G.S. 130A-337(a)(b). If the malfunctioning wastewater system is brought into compliance, no further action will be taken.

7. The Environmental Health Specialist may extend the time for compliance [as **allowed in 15A NCAC 18E.1306(c)**] (i.e. adverse weather, circumstances beyond the owners control, good faith efforts, etc.)

8. If 30 days or the specified time (based on the longer amount of time) elapses and the malfunctioning wastewater system has not been brought into compliance, the Environmental Health Specialist may send a second NOV to the **property** owner. This notice will inform the owner that failure to bring the malfunctioning wastewater system into compliance within ten (10) days or the specified time period, will result in the matter being referred to the Rockingham County Legal Department.

9. After the Environmental Health Specialist confirms that the owner has failed to comply with the second NOV, the Specialist shall forward this violation and supporting documentation to the Rockingham County Legal Department for review and determine appropriate legal action for the malfunction [as defined in **Rule .1306(i)].**

10. Appeals:

    If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ALTERNATIVE WASTEWATER SYSTEM PERMITTING OPTIONS

DATE DEVELOPED: 2/24
REVIEWED: 6/24
REVISED:

I. POLICY:

The owner of a wastewater system may obtain an NOI (Notice of Intent) from a PE (Professional Engineer) or AOWE (Authorized Onsite Wastewater Evaluator) as an alternative to obtaining an Improvement Permit or Construction Authorization from Environmental Health per 15A NCAC 18E.0207.

II. PURPOSE:

To implement alternative wastewater system permitting options per G.S. 130A-336.1 and G.S. 130A-336.2.

III. GUIDELINES:

A. Central Permitting processes NOI documentation submitted by PE or AOWE.

B. Environmental Health retains NOI documentation in TRAKiT.

C. When the PE or AOWE submits the Authorization to Operate (ATO), Environmental Health retains ATO documentation in TRAKiT.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: AUTHORIZED ONSITE WASTEWATER EVALUATOR (AOWE) HYBRID PERMITS

DATE DEVELOPED: 6/93
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 2/24; 6/24
REVISED: 6/19; 6/20; 6/22; 6/23; 2/24

I. POLICY:

Environmental Health conducts completeness reviews of Authorized Onsite Wastewater Evaluator (AOWE) Improvement Permit and Construction Authorization submissions based on the current version of G.S. 130A-335 (a2)(a3).

II. PURPOSE:

Per the current version of 130A-335 (a2)(a3), Environmental Health conducts a completeness review of AOWE submittal within five (5) business days of receipt.

III. GUIDELINES:

A. **Central Permitting processes AOWE (a2)(a3) Improvement Permit (IP) and/or Construction Authorization (CA) submissions.**

B. **The specialist reviews the AOWE IP and/or CA submission for completeness within five (5) business days of receipt per 130A-335 (a2)(a3). If the specialist finds the submission is incomplete, the specialist shall notify the applicant of the components needed to complete the IP and/or CA.**

C. **The septic system installation is inspected by Environmental Health according to the AOWE IP/CA submission. Environmental Health issues the Operation Permit when the installation is approved according to the AOWE IP/CA submission.**

Rev/di

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK BENTON • Deputy Secretary for Health
SUSAN KANSAGRA • Assistant Secretary for Public Health
Division of Public Health

July 6, 2022

POSITION STATEMENT: Development Reform 2022

PURSUANT TO: Session Law 2022-11 (S372)

SOURCE: Jon Fowlkes, Branch Head, On-site Water Protection Branch

ISSUE: Implementation of Session Law Provisions

DISCUSSION AND RATIONALE:

Session Law 2022-11 (S372) has multiple sections that affect the on-site wastewater industry. This document is intended to provide the Division's interpretation of the language in this Session Law to local health departments (LHDs) and industry professionals to help promote consistency statewide. This information is presented according to the Section in the Session Law that addresses each issue.

Please note that Sections 2.(a), 2.(b), 4, 5.(a), 5.(b), 5.(c), 5.(d), 5.(e), and 5.(f) became immediately effective when this Session Law was signed into law by Governor Cooper on June 29, 2022. Section 6.(a) becomes effective October 1, 2022. In addition, Section 11.(c) of the "Regulatory Reform Act of 2018" position statement issued by the Division on July 24, 2018 is no longer valid.

Newly adopted on-site wastewater rules 15A NCAC 18E, Section 2.(a) and 2.(b):
Delays the implementation of 15A NCAC 18E (newly adopted on-site wastewater rule not effective until January 1, 2024), while also keeping 15A NCAC 18A .1900 (current on-site wastewater rules) in effect until 15A NCAC 18E becomes effective.

LSS-COVID Permitting under GS 130A-336.2, Section 4:
Amends Section 3.19.(e) of Session Law 2020-97 that currently allows permitting by Licensed Soil Scientists (LSS) under the coronavirus emergency to expire on January 1, 2023. This section also amends the following language:

> *"However, the expiration of this section shall not prevent a licensed soil scientist acting under this section's authority from completing a ~~proposed~~ wastewater system ~~begun before this section expires.~~ already under construction."*

Please refer to the N.C. Septic Tank Association Fact Sheet issued on July 1, 2022 (attached to this document) for more information and guidance on this Section.

(DOUBLE CLICK WITHIN PAGE TO VIEW FULL DOCUMENT)

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2021

SESSION LAW 2022-11
SENATE BILL 372

AN ACT TO MAKE VARIOUS CHANGES TO ELECTRICAL CONTRACTING LICENSES, WASTEWATER, SEDIMENTATION, AND BUILDING CODE LAWS.

The General Assembly of North Carolina enacts:

MODIFY CLASSIFICATION OF ELECTRICAL CONTRACTING LICENSES

SECTION 1.(a) G.S. 87-43.3 reads as rewritten:

"**§ 87-43.3. Classification of licenses.**

(a) An electrical contracting license shall be issued in one of the following classifications:

(1) Limited, under which a licensee shall be permitted to engage in a single electrical contracting project of a value, as established by the Board, not in excess of one hundred thousand dollars ($100,000) and on which the equipment or installation in the contract is rated at not more than 600 ~~volts;~~ volts. The limited classification and any special restricted classifications shall require no more than 3,000 hours of experience, of which, no less than 2,000 hours shall consist of primary experience gained by direct installation of electrical wiring and equipment governed by the National Electric Code.

(2) Intermediate, under which a licensee shall be permitted to engage in a single electrical contracting project of a value, as established by the Board, not in excess of two hundred thousand dollars ~~($200,000);~~ ($200,000). The intermediate classification shall require no more than 5,750 hours of experience, of which, no less than 5,000 hours shall consist of primary experience gained by direct installation of electrical wiring and equipment governed by the National Electric Code.

(3) Unlimited, under which a licensee shall be permitted to engage in any electrical contracting project regardless of ~~value; and~~ value. The unlimited classification shall require no more than 9,000 hours of experience, of which, no less than 8,000 hours shall consist of primary experience gained by direct installation of electrical wiring and equipment governed by the National Electric Code.

(b) An electrical contracting license shall be issued in such other special Restricted classifications as the Board may establish from time to time to provide, (i) for the licensing of persons, partnerships, firms or corporations wishing to engage in special restricted electrical contracting, under which license a licensee shall be permitted to engage only in a specific phase of electrical contracting of a special, limited nature, and (ii) for the licensing of persons, partnerships, firms or corporations wishing to engage in electrical contracting work as an incidental part of their primary business, which is a lawful business other than electrical contracting, under which license a licensee shall be permitted to engage only in a specific phase of electrical contracting of a special, limited nature directly in connection with said primary business.

(c) The Board may establish appropriate standards for each classification, such standards not to be inconsistent with the provisions of G.S. 87-42. The Board may, by rule, modify the

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PRIVATE DRINKING WATER WELLS

DATE DEVELOPED: 04/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18; 6/22; 6/23; 6/24

I. POLICY:

Well Construction Permit **field evaluations are conducted** in accordance with State rules for well construction, permitting, contractor duties, application requirements, water supply protection, and private drinking water well sampling rules.

II. PURPOSE:

To provide well-head protection to maintain a clean, safe water supply in accordance with Article 7 of the North Carolina Well Construction Act § 87-88 General standards and requirements and § 87-97 Permitting, inspection, and testing of private drinking water wells along with 15A NCAC 02C Section .0300 – Permitting and Inspection of Private Drinking Water Wells and 15A NCAC 2C .0100 Well Construction Rules.

III. GUIDELINES:

A. An application, including a site plan, shall be submitted requesting a permit to construct a new well or repair an existing well **according to 15A NCAC 02C. 0303.**

B. The Environmental Health Specialist (EHS) shall issue or deny a permit to construct a well as determined by a site evaluation. **A written notice of denial of a construction permit that references specific laws or rules that cannot be met will be provided to the applicant.** The permit shall contain a drawing showing the location of the proposed well area and location of:

1. Property lines
2. Building foundations
3. Proposed well area and existing wells
4. Easements and rights-of-way
5. Adjacent on-site sewage systems
6. Surface water bodies
7. Other potential sources of contamination
8. **Known releases of contamination within 1,000 feet of the proposed well site, and any known risk of constructing the well related to those findings.**

C. **For new well construction**, the Environmental Health Specialist shall visit the site and verify that the proposed location meets the requirements of the Rules and Regulations.

1. During this visit, a tape measure shall be used to measure the distance from the:

    a. Structure
    b. Property lines
    c. Easements
    d. Rights-of-way
    e. Septic tank system(s) (both on the respective lot and adjoining lots, if this applies)

2. Property lines, easements, rights-of-way, etc., must be clearly identified on site.

3. During the visit, the location of the well will be GPS located.

D. **For repairs to existing wells, a permit shall be issued for work in deepening, reaming, sealing, installing or changing casing depths, perforating, screening, or cleaning, acidizing or redevelopment of a well excavation, or any other work which results in breaking or opening the well seal (NC G.S. 87-85).**

E. Appeals

1. If a well permit is denied, a second opinion may be conducted by a Rockingham County OSWW Program Coordinator upon request from the applicant, owner and/or agent.

2. If the well permit is denied by the Rockingham County OSWW Program Coordinator, the applicant, owner and/or agent will be notified of their right to request an informal appeal to the state Regional Environmental Health Specialist.

3. If the well permit is denied by the state Regional Environmental Health Specialist, the applicant, owner and/or agent will be notified of their right to appeal to the North Carolina Office of Administrative Hearings.

4. If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: FOOD, LODGING, AND INSTITUTIONS

DATE DEVELOPED: **4/04**
REVIEWED: **6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/17; 6/18; 6/22**

I. POLICY:

Food, Lodging and Institution inspections shall be conducted in accordance with the following rules: North Carolina General Statutes 130A-247 through 130A-250, Rules Governing Food Protection and Sanitation of Food Establishments 15A NCAC 18A .2600, North Carolina Food Code Manual, Instructions for Marking the Food Establishment Inspection Report, Rules Governing the Sanitation of Lodging Establishments, 15A NCAC 18A .1800, Lodging Rules Marking Instructions, Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions, 15A NCAC 18A .1300, Rules Governing the Sanitation of Summer Camps, 15A NCAC 18A .1000, Rules Governing the Sanitation of Local Confinement Facilities, 15A NCAC .1500, Rules Governing the Sanitation of Residential Care Facilities, 15A NCAC 18A .1600, Rules Governing the Sanitation of Adult Day Service Facility, 15A NCAC 18A .3300, North Carolina Administrative Code Title 15A Well Construction Standards, Subchapter 2C section .0100 and .0300, Water Well Sampling section .3800, and Chapter 27 section .0100-.0900 Well Construction Certification Rules Governing the Sanitation of Protection of Water Supplies, 15A NCAC 18A .1700, Rules Governing the Sanitation of Primitive Camps 15A NCAC 18A .3500, Rules Governing the Sanitation of Resident Camps 15A NCAC 18A .3600.

II. PURPOSE:

Inspections are conducted to determine compliance with existing rules and to produce documentation of conditions present at the time of inspection. This time is also used to educate the person in charge of the establishment.

III. GUIDELINES:

A. 1. Environmental Health Specialists shall conduct inspections at least as often as required by North Carolina General Statutes 130A-247 through 250:

- Food Establishments 15A NCAC 18A.2661(h)
- Hospitals, Nursing Homes, Adult Care Homes & Other Institutions 15A NCAC 18A .1307
- Resident Camps 15A NCAC 18A .3605(h)
- Primitive Camps 15A NCAC 18A .3504

- Lodging Establishments 15A NCAC 18A .1831(e)
- Local Confinement Facilities 15A NCAC 18A.1504
- Residential Care Facilities 15A NCAC 18A. 1604
- Adult Day Service Facilities 15A NCAC 18A .3334(b)(4)

2. Regulation of Food and Lodging Facilities, which requires inspections of each of the above listed facilities at a frequency established by the Commission for Public Health as stated in Rule 10A NCAC 46.0213.

3. The Environmental Health Specialist shall handle priority and priority foundation violations found during an inspection as required under 15A NCAC 18A. 2661(f).

4. Upon receiving a request for a re-inspection for the purpose of raising the alphabetical grade or improving a classification, the Environmental Health Specialist shall make an unannounced inspection as required by regulations.

B. The Environmental Health Specialist shall complete the applicable inspection forms at the time of the inspection. The Environmental Health Specialist may use additional forms as needed. The forms used are:

1. Food Establishment Inspection Report, EHS 4007
2. Inspection of Lodging Establishment, EHS 3977
3. Inspection of Hospitals, Nursing Homes, Adult Care Homes and other Institutions, EHS 1213
4. Inspection of Summer Camp, EHS 1050
5. Inspection of Local Confinement Facility, EHS 1268
6. Inspection of Adult Day Service Facility, EHS 4054
7. Inspection of Residential Care Facility, EHS 2094
8. Inspection of Primitive Experience Camps, EHS 4061
9. Inspection of Resident Camps, EHS 3601
10. Comment Addendum, EHS 4008
11. Intent to Suspend or Revoke Permit, EHS 4009A
12. Immediate Permit Suspension or Revocation, EHS 4009B
13. Variance Request Form

14. Embargo Product Disposition Form, EHS 6002
15. Notice of Termination of Embargo, EHS 6003
16. Embargo Tags, EHS 6001
17. Rockingham County Department of Health and Human Services Notice of Violation: Operation without a permit
18. English/Spanish Handwashing Card, EHS 1026
19. Grade "A" Placard**,** EHS 1097
20. Grade "B" Placard, EHS 1098
21. Grade "C" Placard, EHS 1099
22. Sanitation Classification Placard, EHS 3772
23. Mushroom Tags, EHS 7000

C. The Environmental Health Specialist follows this procedure when conducting a Food Establishment Inspection:

1. Upon entry, introduce her/his self and notify the person in charge of the purpose of the visit.
2. Invite the person in charge to accompany her/him during the inspection.
3. Wash hands before beginning the inspection.
4. Evaluate all Risk Factors first such as food temperatures, food handling practices, sources of food, employee hygiene and the cleaning and sanitizing of food contact surfaces. All food and water temperatures along with violations and general comments are documented on a note pad during the inspection in order to more accurately record a detailed inspection report.
5. After looking at all Risk Factor items, the Environmental Health Specialist shall inspect all Good Retail Practice items.
6. After all required items have been inspected, the Environmental Health Specialist shall complete EHS 4007 and EHS 4008 on a laptop using CDP Mobile software in as much detail as possible to thoroughly document the inspection.
7. The Environmental Health Specialist shall review the inspection report with the person in charge and offer suggestions on how to correct violations found. While reviewing the report, the

Environmental Health Specialist shall answer any questions the person in charge may have.

8. The person in charge shall sign the inspection report and the Environmental Health Specialist shall post the new Grade Card(s) in the same location as before or in a conspicuous place.

D. The Environmental Health Specialist follows this procedure when conducting a Lodging or Institution Inspection Procedure:

1. Upon entry, introduce himself/herself and notify the person in charge of the purpose of the visit.

2. Invite the person in charge to accompany him/her during the inspection.

3. Start inspection, checking all required items for that establishment and recording any violations on a note pad during the inspection in order to more accurately record a detailed inspection report.

4. Inspect every aspect of every establishment with the exception of:

   a. Lodging facilities where a minimum of 10%-20% of guest rooms must be inspected.
   b. Hospitals and Nursing Homes where a minimum of 10%-20% of all patient rooms must be inspected.

5. Fill out the applicable inspection form for that type of establishment on a laptop using CDP Mobile software. The report shall have as much detail as possible to thoroughly document the inspection including any violations.

6. Review the inspection report with the person in charge and offer suggestions on how to correct any violations. After reviewing the inspection report, the Environmental Health Specialist shall answer any questions the person in charge may have.

7. The person in charge shall sign the inspection report and the Environmental Health Specialist shall post the new Grade Card(s), if applicable, in the same location as before or in a conspicuous place.

E. Documentation shall be handled as follows:

1. A printed copy shall be left with the person in charge at the time of the inspection or emailed to the person in charge, whichever is preferred.

2. A copy of the inspection shall be placed in the Environmental Health files and kept in accordance with the Records Retention and Disposition Schedule issued by the N.C. Department of Cultural

Resources, including any results from the State Laboratory of Public Health and a copy of a notice or letter indicating sample results.

F. Appeals:

If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CHILD CARE CENTERS AND SCHOOLS

DATE DEVELOPED: 4/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18; 6/19; 6/22

I. POLICY:

Child care center inspections shall be conducted in accordance with the Rules Governing the Sanitation of Child Care Facilities, 15A NCAC 18A .2800 and school building inspections shall be conducted in accordance with the Rules Governing the Sanitation of Public, Private and Religious Schools, 15A NCAC 18A .2400.

II. PURPOSE:

A. Inspections are conducted to determine compliance with existing rules and to provide the Division of Child Development and Early Education documentation of sanitation conditions observed at the time of child care center inspection.

B. Inspections are conducted to determine compliance with existing rules and to produce documentation of conditions observed at the time of the school building inspection.

III. GUIDELINES:

A. Environmental Health Specialists conduct inspections for existing Child Care Centers as often as required by 15A NCAC 18A .2834.

1. The Environmental Health Specialist shall send all Provisional and Disapproval Classifications to the Division of Child Development and Early Education (DCDEE) Regulatory Services Chief in Raleigh.

2. If a child care center receives a Disapproval Classification during a routine sanitation inspection, a reinspection will be done only when the child care operator requests the inspection.

B. Proposed child care centers shall submit plans and specifications as required in 15A NCAC 18A .2802 and contact Environmental Health to schedule an inspection of the proposed facility.

When an inspection is requested and conducted for the purpose of issuing a license to a new operator of an existing child care center, the Environmental

Health Specialist shall meet the requirements of 15A NCAC 18A .2834(e)(1).

C. Environmental Health Specialists conduct inspections for School Buildings as often as required by 15A NCAC 18A .2402.

D. The Environmental Health Specialist shall complete the applicable inspection forms at the time of the child care center or school building inspection. The Environmental Health Specialist may use additional forms as needed. The forms used are:

1. Child Care Center Inspection Form EHS 1617
2. Comment Addendum form EHS 4008
3. Schools Inspection Form EHS 1163
4. Sanitation Classification Placard for Child Day Care, EHS 3772
5. English/Spanish Handwashing Card, EHS 1026

E. Child Care Center Inspection Procedure:

1. Upon entry into a child care center facility, the Environmental Health Specialist shall introduce herself/himself and notify the responsible person of the purpose of the visit.
2. The Environmental Health Specialist shall then invite the responsible person to accompany her/him during the inspection.
3. The Environmental Health Specialist shall wash their hands before beginning the inspection.
4. The Environmental Health Specialist shall start the inspection, checking all required items and recording water temperatures and any violations on a note pad during the inspection in order to more accurately create a detailed inspection report.
5. After all required items have been inspected, the Environmental Health Specialist shall complete the inspection report on a laptop with CDP Mobile software using as much detail as possible to thoroughly document the inspection.
6. The Environmental Health Specialist shall discuss the inspection report with the responsible person and may offer suggestions on how to correct violations. After discussing the report, the Environmental Health Specialist shall answer questions the responsible person may have.

7. The Environmental Health Specialist shall post the Sanitation Classification Placard in a conspicuous place.

8. Appeals concerning the enforcement of the Child Care Sanitation Rules will be done in accordance with 15A NCAC 18A .2835.

F. School Building Inspection Procedure:

1. Upon entry into a school building, the Environmental Health Specialist shall introduce herself/himself and notify the responsible person of the purpose of the visit.

2. The Environmental Health Specialist shall then invite the responsible person to accompany her/ him during the inspection.

3. The Environmental Health Specialist shall start the inspection, checking all required items and recording violations on a note pad during the inspection in order to more accurately create a detailed inspection report.

4. After all required items have been inspected, the Environmental Health Specialist shall complete the inspection report on a laptop with CDP Mobile software using as much detail as possible to thoroughly document observations made during the inspection.

5. The Environmental Health Specialist shall discuss the inspection report with the responsible person and may offer suggestions on how to correct violations. After discussing the report, the Environmental Health Specialist shall answer questions the responsible person may have.

6. The Environmental Health Specialist shall ask the responsible person to sign the inspection report before leaving a copy.

7. Appeals concerning the interpretation and enforcement of the Rules Governing the Sanitation of Public, Private and Religious Schools will be done in compliance with 15A NCAC 18A .2417.

8. If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

G. Records shall be handled as follows.

A copy of the inspection report shall be left with the responsible at the site.

1. Child care centers receive a copy of the inspection report.

a. A copy shall be forwarded to the Division of Child Development and Early Education, or
b. In the case of a dangerous situation, the Environmental Health Specialist shall also notify the Division of Child Development and Early Education verbally within 24 hours.

2. Schools receive a copy of the inspection report.

3. A copy of the inspection report shall be placed in the Environmental Health files and kept in accordance with the Records Retention and Disposition Schedule issued by the N.C. Department of Cultural Resources, including any results from the State Laboratory of Public Health and a copy of a notice or letter indicating sample results.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PUBLIC SWIMMING POOLS

DATE DEVELOPED: 4/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18; 6/20; 6/24

I. POLICY:

Public swimming pool **(including water recreation attractions)** permitting and inspections shall be conducted in accordance with the North Carolina General Statues 130A-280 through 130A-282 and the Rules Governing Public Swimming Pools, 15A NCAC 18A .2500.

II. PURPOSE:

A. Inspections are conducted to determine compliance with existing rules, verify documentation required by the rules, and to produce documentation of conditions present at the time of the inspection.

B. To ensure that newly constructed public swimming pools meet the requirements of North Carolina General Statue 130A-282 and rule 15A NCAC 18A .2509.

III. GUIDELINES

A. The Environmental Health Specialist shall permit all public swimming pools as required by 15A NCAC 18A.2510. Unless suspended or revoked, the operation permit shall be valid for the period of operation specified on the application but in no event shall it be valid for more than 12 months.

Permitting Procedure:

1) Public swimming pool operators shall complete the Application for Public Swimming Pool Operation Permit form EHS 3961 and pay the required Annual Operation Permit fee.

   a. Once the application and permit fee have been received, the Environmental Health Specialist will contact the pool operator to schedule an appointment to evaluate the pool for an operation permit.
   b. If the pool is in compliance with all applicable rules and no six-demerit or four-demerit items are observed, an operation permit will be issued using form EHS 3962.

c. If an operation permit is not issued because of violations found during the inspection, the pool operator must pay a revisit fee and schedule an appointment for the Environmental Health Specialist to conduct a second evaluation for an operation permit provided that no six-demerit or four-demerit items are observed.

2. New proposed public swimming pools shall provide plans and specifications as required by the rule 15A NCAC 18A.2509 and pay the required Swimming Pool Plan Review fee prior to construction.

a. Plans will be reviewed as required under 15A NCAC 18A .2509.
b. Approved plans are valid for one year.
c. The Environmental Health Specialist must conduct an open-pipe inspection during construction as required under 15A NCAC 18A .2509(e).
d. Before issuance of the operation permit, the owner must submit a signed statement stating that construction is complete and in accordance with approved plans and specifications and approved modifications, including final inspection for design compliance from the registered design professional as required in 15A NCAC 18A .2509(f).
e. The owner shall apply for the operation permit by providing a completed Application for Public Swimming Pool Operation Permit form EHS 3961 and pay the required Annual Operation Permit fee.

i. Once an application and permit fee have been received, the Environmental Health Specialist will contact the pool operator to schedule an appointment to evaluate the pool for an operation permit.
ii. If the pool is in compliance with all applicable rules and no six-demerit or four-demerit items are observed, an operation permit will be issued using form EHS 3962.
iii. If an operation permit is not issued because of violations found during the inspection, the pool operator must pay a revisit fee and schedule an appointment for the Environmental Health Specialist to conduct a second evaluation to issue the operation permit provided that no six-demerit or four-demerit items are observed.

B. Environmental Health Specialists conduct inspections of public swimming pools as often as required by 15A NCAC 18A .2511.

1. The Environmental Health Specialist shall complete the applicable inspection form at the time of the inspection. The Environmental Health Specialist may use additional forms as needed. The forms used are:

    a. Public Swimming Pool Inspection form EHS 3960
    b. Comment Addendum form EHS 4008
    c. Intent to Suspend or Revoke form EHS 4009A
    d. Immediate Suspension or Revocation form EHS 4009B

2. Public Swimming Pool Inspection Procedures:

    a. Upon entry into a public swimming pool, the Environmental Health Specialist shall introduce himself/herself and notify the responsible person of the purpose of the visit.
    b. The Environmental Health Specialist shall invite the responsible person to accompany him/her during the inspection.
    c. The Environmental Health Specialist shall begin the inspection by checking all six-demerit items first in order to allow the responsible person time to make corrections if violations are found.

        1) Six-demerit items are failures to maintain minimum water quality or safety standards and warrant immediate suspension of an operation permit **under G.S. 130A-23(d)** if not corrected during the inspection.
        2) After all six-demerit items have been inspected, the Environmental Health Specialist shall check all remaining four-demerit and two-demerit items.

            - Four-demerit items are rule violations which warrant notification of intent to suspend operation permit.
            - Two-demerit items are rule violations which do not warrant permit action unless it causes an imminent hazard, failure to meet water quality or safety standard, or a suction hazard.

        3) Once all required items have been inspected, the Environmental Health Specialist shall complete the inspection report on a laptop using CDP Mobile Software, with as much detail as possible to thoroughly document all observations made during the inspection, including water quality test results and water temperatures.

4) The Environmental Health Specialist shall review the inspection report with the responsible person and offer suggestions on how to correct any violations. After reviewing the report, the Environmental Health Specialist shall answer questions the responsible person may have.
5) The Environmental Health Specialist shall ask the responsible person to sign the inspection report before leaving a copy.

3. Documentation shall be handled as follows:

a. The inspection form and permit, if issued, shall be left with a responsible person at the site.
b. A copy of the inspection report and permit, if issued, shall be placed in the Environmental Health files and kept in accordance with the Records Retention and Disposition Schedule issued by the N.C. Department of Cultural Resources, including any results from the State Laboratory of Public Health and a copy of a notice or letter indicating sample results.

- For all pools, the assigned number shall be used for consecutive years until the number is cancelled for a valid reason such as closing of the unit.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TATTOO ARTISTS

DATE DEVELOPED: 4/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18

I. POLICY:

Pursuant to GS 130A – 283, tattoo artist permitting and inspections shall be conducted in accordance with the Rules Governing Tattooing, 15A NCAC 18A .3200.

II. PURPOSE:

To determine compliance with existing rules, verify documentation required by the rules, and to produce documentation of conditions present at the time of inspection.

III. GUIDELINES:

A. Permitting Procedure – The Environmental Health Specialist shall permit all tattoo artists as required in rule 15A NCAC 18A .3202. Permits are valid for one year and must be renewed annually by application.

1. Applicants shall provide a completed application (Form EHS 4015) and pay the required Tattoo Artist Permit Application fee prior to anticipated commencement of tattooing by the artist.

2. Environmental Health Specialist contacts the applicant to schedule an inspection within 30 calendar days of receiving application and fee.

3. The Environmental Health Specialist shall complete the applicable inspection forms at the time of the inspection. The Environmental Health Specialist may use additional forms as needed. The forms used are:

   a. Tattoo Establishments Inspection Form, EHS 4014
   b. Comment Addendum Form, EHS 4008
   c. Tattooing Permit Form, EHS 4016
   d. Intent to Suspend or Revoke Form, EHS 4009A
   e. Immediate Suspension or Revocation Form, EHS 4009B

4. Inspection Procedure – The Environmental Health Specialist shall conduct inspections of tattoo artists as often as required by 15A NCAC 18A .3200.

a. Upon entry into a tattooing establishment, the Environmental Health Specialist shall introduce himself/herself and notify the applicant of the purpose of the visit.
b. The Environmental Health Specialist shall begin the inspection by looking at the artist's work station, asking questions about his/her tattoo procedure, looking at his/her endospores test results, if applicable, and looking at patron records.
c. After all required items have been inspected, the Environmental Health Specialist shall complete the inspection report on a laptop using CDP Mobile software, with as much detail as possible to document any observations made during the inspection.
d. The Environmental Health Specialist shall review the inspection report with the tattoo artist and answer questions.
e. The Environmental Health Specialist shall ask the tattoo artist to sign the inspection report before leaving a copy.

5. If it is determined that all requirements have been met, a Tattooing Permit will be issued.

   a. For renewal permits issued to the same artists at the same address, the same Facility ID number shall be used.
   b. For renewal permits issued to the same artist at a different address, a new Facility ID number shall be issued.
   c. For new permits issued, a new Facility ID number shall be issued.

6. The permit automatically expires after one year unless the tattoo artist leaves or moves to a different tattoo establishment. If the permit has not been renewed, the Environmental Health Specialist will complete an inspection form canceling the permit using CDP Mobile software.

7. Documentation shall be handled as follows:

   a. The inspection report and permit shall be left with the artist.
   b. A copy of the inspection report and permit shall be placed in the Environmental Health files and kept in accordance with the Records Retention and Disposition Schedule issued by the N.C. Department of Cultural Resources, including any results from the State Laboratory of Public Health and a copy of a notice or letter indicating sample results.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
POLICY

TITLE: LEAD INVESTIGATION

DATE DEVELOPED: 4/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18; 6/22; 6/23

I. POLICY:

Lead investigations shall be conducted in accordance with the North Carolina General Statutes G.S. 130A-131.5-131.9H the Rules Governing Childhood Lead Poisoning Prevention Program, 15A NCAC 18A .3100 and the Appropriations Act of 2017 / Session Law 2017-57 / Senate Bill 257 / Section 11E.6: Implementation of the federal elevated blood lead standard in North Carolina (amends NCGS 130A-131.7 and 130A-131.9).

II. PURPOSE:

The Environmental Health Specialist shall assist the Regional Environmental Health Specialist (REHS) in conducting the lead investigation as required by the laws and rules listed above.

III. GUIDELINES:

A. When it is determined a lead investigation is needed, the Environmental Health Specialist shall set an appointment with the REHS to conduct an inspection.

1. An investigation shall be conducted when Environmental Health is notified of a child with lead poisoning or elevated blood lead level as defined in the North Carolina General Statute G.S. 130A-131.7. An inspection for an elevated blood lead level is conducted only after parental consent is given in writing.

2. An investigation is offered to the parent and may be conducted by the REHS with our assistance for a child with a confirmed elevated blood lead level.

3. An investigation shall be conducted when it is determined that a child-occupied facility was constructed prior to 1978 and there is a concern of lead poisoning hazards.

B. The Environmental Health Specialist shall collect the following forms and supplies if available:

1. Lead-Based Paint Inspection Form, DENR 3279
2. Environmental Sciences Analysis Report, DHHS form 2364
3. Environmental Activity Report
4. Exposure History of Child with Elevated Blood Lead Level, EHS form 3651
5. Environmental Investigation for Lead Hazards, DHHS 3460
6. Lead Screening Risk Assessment Questionnaire, EHS 3958
7. Special Lead Analysis of Drinking Water Request and Chain of Custody Record, DHHS 4122
8. Preventing Lead Poisoning in Young Children – English
9. Preventing Lead Poisoning in Young Children – Spanish
10. Diagram of Building Components
11. Large sealable envelopes in assorted sizes
12. Self-adhesive labels large enough for all required information and a permanent marker.
13. Blank paper, pens, pencils, ruler, and clipboard.

C. The Environmental Health Specialist shall complete the Lead-Based Paint Inspection form and the Environmental Lead Analysis Request and Chain of Custody Record.

D. The Environmental Health Specialist shall assist the REHS at the investigation site.

E. The Environmental Health Specialist shall assist in completion of documentation as directed by the REHS, and if needed transport the samples to the courier box located at the Division of Public Health.

F. The Environmental Health Specialist shall maintain copies of all documentation completed in a labeled file folder in the locking file cabinet designated for all lead and rabies files in the Environmental Health Section office.

The Environmental Health Specialist shall collect a water sample to be tested for lead. In collecting a water sample for lead analysis, follow the sampling protocol attached to the Rockingham County Department of

Health and Human Services Policy – Water Samples and Water Protection (EH-21).

The Environmental Health Specialist shall forward a copy of the water sample results to the REHS, the parent or guardian of the child involved, and the owner of the property if they have not already been notified.

G. Once the State Laboratory of Public Health has forwarded the results of the environmental samples to Environmental Health and the REHS has written the lead report, the Environmental Health Specialist shall mail copies as required under G.S. 130A-131.9B.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: REPORTING OF ANIMAL BITE

DATE DEVELOPED: 7/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/18; 6/20; 6/22; 6/23

I. POLICY:

Animal bites that may indicate an exposure to the rabies virus are reported to the Environmental Health Section of the Division of Public Health.

II. PURPOSE:

To protect the public health and help control the spread of rabies by uniform reporting of animal bites to the health director, as required by General Statute 130A-196 and the Rockingham County Animal Control Ordinance and Amendment to the Animal Control Ordinance.

III. GUIDELINES:

A. Domestic animal bites, such as dog and cat bites, are reported to the local Law Enforcement agency that has jurisdiction at the location where the bite occurred.

1. Bites occurring in one of the county's municipalities are reported to the Police Department serving that municipality.

2. Bites occurring outside of a municipality or in Wentworth are reported to the Rockingham County Sheriff's Department.

B. All local Law Enforcement agencies have agreed to send a copy of the animal bite Incident Report to the Environmental Health Section by the next weekday after the incident is investigated.

The incident report should include the following information:

1. Name, age, sex, address, phone number and location of the wound of the person/animal bitten.

2. Name, address and phone number of the domestic animal owner.

3. Breed and name of animal that bit or attacked.

C. The possible rabies exposure is reported to Environmental Health to investigate. Most bite reports may be routinely investigated by police and animal control of the law enforcement agency of jurisdiction. Environmental Health will:

1. Complete a Rabies Incident Questionnaire.

2. Verify that the biting animal has been confined for 10 days.

    a. If the biting animal is current on its rabies vaccination, it may be confined at home.
    b. If the biting animal is not up to date on its rabies vaccination, it must be confined at the Rockingham County Animal Shelter (RCAS) or another approved facility, as determined by the responding Animal Control Officer.

3. After the 10-day confinement, follow-up with RCAS to determine if the animal was removed/picked up from confinement and verify that any unvaccinated animals have now been vaccinated for rabies or with the animal owner if confined at home.

4. The Communicable Disease Nurse will determine human exposure.

D. The completed Rabies Incident Questionnaire will be filed by year and type of exposure in the locked Rabies file cabinet in the Environmental Health office and kept in accordance with the Records Retention and Disposition Schedule issued by the N.C. Department of Cultural Resources, including any results from the State Laboratory of Public Health and a copy of a notice or letter indicating sample results.

E. All investigations are reviewed by the EH Director prior to filing.

F. Animal control officers and law enforcement officers needing assistance may call the Environmental Health office of the Health and Human Services Department from 8:00 a.m. – 5:00 p.m. Monday through Friday at 336-342-8180. They may call for assistance after hours and on weekends by calling the County Communications Center at 336-634-3300, and asking the dispatcher to contact Environmental Health.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: HAZARD ANALYSIS OF CRITICAL CONTROL PLANS (HACCP) VERIFICATION FOR RETAIL FOOD

DATE DEVELOPED: 2/18
REVIEWED: 2/18; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

A HACCP verification will be done annually in retail food establishments which have an approved HACCP plan.

II. PURPOSE:

To develop a policy for the verification of HACCP plans in retail food establishments. When specialized processes occur in retail food establishments, they are required to submit HACCP plans and/or a variance application. These processes can pose higher risks if there is an error in any of the critical control points of the process.

Verification ensures that the HACCP plan is adequate and is working as intended. Verification procedures include such activities as review of HACCP plans, Critical Control Point (CCP) records, critical limits, and microbial sampling and analysis.

III. GUIDELINES:

Depending on the type of approved HACCP plan, Environmental Health may have to make several announced visits to the establishment and the REHS will use the verification process provided in the FDA Procedures for Standardization to conduct the verification.

In the event that the county has no HACCP plans, each REHS responsible for HACCP verification will attended training and/or visit a neighboring county to conduct verification.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: OATH OF OFFICE

DATE DEVELOPED: 6/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18

I. POLICY:

All newly employed Environmental Health Specialists are sworn into office upon employment. This is a policy of the Rockingham County Board of Health and Human Services. It is the position of the Rockingham County Board of Health and Human Services that these employees are public officials.

II. PURPOSE:

Provide public official status for Environmental Health Specialists.

III. GUIDELINES:

Upon employment, all Environmental Health Specialists will be sworn in by the Clerk to the Board of County Commissioners.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ENVIRONMENTAL HEALTH EMERGENCY RESPONSE

DATE DEVELOPED: 3/20
REVIEWED: 3/20; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/24

I. POLICY:

The Division of Public Health will maintain a Registered Environmental Health Specialist call down list for response to environmental emergencies as requested as part of a functional ICS network through Local Emergency Management Agencies (LEM).

II. PURPOSE:

To provide Environmental Health response that can assist Emergency Responders.

III. GUIDELINES:

A. Environmental Health will provide Rockingham County Emergency Management with a list of responding staff members and their phone numbers.

B. Upon receiving a call from Central Communications notifying Environmental Health of an environmental emergency, the staff member will obtain as much information as possible from the LEM on scene to determine what type of local Environmental Health response is needed.

C. If it is necessary to go on site of the emergency, approach the scene cautiously and check in with Incident Command.

D. Enter the area only when wearing appropriate personal protective equipment (refer to Rockingham County Emergency Operations Plan; Agency Standard Operating Procedures; and/or Agency OSHA Manual: Policy IC-16, which pertains to Environmental Health).

IMPORTANT REMINDERS:

- Do not walk into or touch spilled material;
- Avoid inhalation of fumes, smoke and vapors, even if no dangerous goods are known to be involved;

- Do not assume that gases or vapors are harmless because of lack of a smell – odorless gases or vapors may be harmful.

E. LEM reports all information to the State Emergency Operations Center at 800-855-0368 or WEBEOC which serves as Immediate State Notification. This agency will take incident information and contact the Winston-Salem Regional Offices of the Division of Water Quality (DWQ) and Division of Waste Management (DWM) of the N.C. Department of Environmental Quality.

IV. TRAINING

Just-In-Time training will be provided on scene by Incident Command, NCDEQ, and other responding agencies, as needed.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EASEMENTS, RIGHTS-OF-WAYS, AND ENCROACHMENT AGREEMENTS FOR ON-SITE WASTEWATER SYSTEMS

DATE DEVELOPED: 3/93
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 2/24; 6/24
REVISED: 6/17; 2/24

I. POLICY:

Easements, Rights-of-Way, or Encroachment Agreements are required when necessary to ensure the entire wastewater system is on property owned or controlled by the person owning or controlling the wastewater system.

II. PURPOSE:

To require that wastewater, treatment and disposal systems are on property owned or controlled by the person owning or controlling the system as required by North Carolina Administrative Code [15A NCAC **18E.0301 (b) and (c)**].

III. GUIDELINES:

A. Necessary easements, rights-of-way, or encroachment agreements, as applicable, shall be filed with the Rockingham County Environmental Health Section prior to the issuance of a Construction Authorization for septic system installation.

B. Terms of the easement, right-of-way or encroachment agreement shall provide that the easement, right-of-way, or encroachment agreement:

1. Is appurtenant to specifically described property, runs with the land, and is not affected by change of ownership or control;

2. Is valid for as long as the wastewater system is required for the facility that it is designed to serve;

3. Describes and specifies the uses being granted and shall include ingress and egress, system installation, operation, maintenance, monitoring, and repairs;

4. Specifies by metes and bounds description or attached plat, the area or site required for the wastewater system and appurtenances including a site for any required system replacement; and

5. Shall be recorded with the Register of Deeds in Rockingham County.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: WATER SAMPLES AND WATER PROTECTION

DATE DEVELOPED: 10/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/18; 6/20; 6/21; 6/23; 6/24

I. POLICY:

Water sample collections of private water supplies and protection of on-site water supplies for all facilities that Environmental Health **regulates**.

II. PURPOSE:

To protect water supplies for private wells and all facilities regulated by Environmental Health.

III. GUIDELINES:

A. This policy is based on the legal authority granted to the local Health agency under G.S. 87-89 and 15A NCAC .0100, .0300, and 15A NCAC 18A .3800, and 15A NCAC 27; G.S. 95-225; 130A-5(3); 130A-230; 130A-235; 130A-236; 130A-248; 130A-257 and is considered one of the essential services under G.S. 130A 1.1 *(water sanitation)*.

B. Section 15A NCAC 18A .1700 are the rules that govern the protection of water supplies for all facilities Environmental Health inspects.

1. These rules are used to determine if water supply meets the definition of "approved" in the following sections of 15A NCAC 18A:

   a. .1000 Sanitation of Summer Camps.
   b. .1300 Sanitation of Hospitals; Nursing Homes; Adult Care Home and other Institutions.
   c. .1500 Sanitation of Local Confinement Facilities.
   d. .1600 Sanitation of Residential Care Facilities.
   e. .1800 Sanitation of Lodging Establishments.
   f. .2100 Rules Governing the Sanitation and Safety of Migrant Housing

g. .2400 Sanitation of Public, Private, and Religious Schools.
h. .2600 Sanitation of Food Service Establishments.
i. .2800 Sanitation of Child Care Centers.
j. .3100 Childhood Lead Poisoning Prevention Program/Lead Investigation and Remediation Manual.

2. When **requested or required**, water samples are collected in an approved manner and the samples are submitted to the State Laboratory of Public Health for analysis**.** Records are kept on file in Environmental Health – including results from the State Laboratory and a copy of a notice or letter indicating sample results.

C. Environmental Health will collect water samples, **interpret water sample results,** and provide educational materials regarding location and protection of water supplies upon request.

D. Environmental Health also acts as a liaison between local citizens and NCDWQ Aquifer Protection Section. Environmental Health makes referrals to other local and state agencies on matters of environmental concern, as they relate to groundwater, that Environmental Health does not regulate directly.

E. There are established fees approved by the Rockingham County Board of Health and Human Services to help offset the costs associated with this program. There is no fee charged for any water sampling that is done when requested by a physician, dentist, and RCHD WIC staff.

Fees associated with this program are for:

- Bacteriological Sample
- Inorganic (chemical) Sample
- Volatile Organic Sample/Petroleum
- Pesticide Sample
- Fluoride Sample
- Nitrate/Nitrite Sample
- Coal Ash Sample

All fees are collected prior to sampling.

F. All water samples are to be packaged for shipment to the Public Health Laboratory on the day they are collected. They are to be sent by N.C. Courier mail service.

G. Water sample collection procedures follow the directions/instructions for each separate type of water analysis performed by the State Laboratory of Public Health in Raleigh.

H. Health Risk Evaluations or HRE's are completed by staff in accordance with state procedure **and are provided to the well owner**.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PERSONAL AND FAMILY MEMBER SERVICE REQUESTS

DATE DEVELOPED: 8/97
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/22; 6/23; 6/24
REVISED: 6/22; 6/24

I. POLICY:

Environmental Health staff members shall not work on personal applications for services, projects, or inspections, including applications or inspections for relatives.

II. PURPOSE:

To provide neutral, non-biased results on all applications for Environmental Health services.

III. GUIDELINES:

A. All personal applications for services, projects or inspections requested by and for members of the Environmental Health staff will be directed to the Environmental Health Director for assignment to a member of the Environmental Health staff.

B. This policy shall include all paid and non-paid personal service requests from members of the Environmental Health staff or from relatives of staff members.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ENVIRONMENTAL HEALTH PUBLIC RECORDS

DATE DEVELOPED: 10/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/22

I. POLICY:

The Division of Public Health provides for inspection and copying of public records (G.S. 132).

II. PURPOSE:

To make inspection of public records available to all persons.

III. GUIDELINES:

A. A public record is any document, regardless of physical form, that is made or received in connection with the public business of any state agency. "Regardless of physical form" means that films, audiotapes, pictures, voicemails, texts, computer files and email, etc. may be considered (G.S. 132-1(a)).

B. Any person may inspect public records from a government agency during reasonable business hours and under reasonable supervision (G.S. 132-6(a)). The individual requesting to see the public records does not have to give any reason why he or she wishes to see the record (G.S. 132-6(b)).

C. Following is the procedure for making public records available:

1. For old fragile records, public access may be restricted to the extent needed to protect the records (G.S. 132-6(f)).

2. Anyone may get copies of public documents from the State and County at a "minimal cost." Minimal cost generally means the cost of the copies themselves, but not the cost of labor or other overhead expenses in the production of the copies. There will be no charge to Governmental Agencies.

3. Environmental Health is only responsible for access to those records under Environmental Health control. This means that Environmental Health does not have a responsibility to make copies of another agency's records. Environmental Health is also not required to create or compile records that do not exist to fulfill a request (G.S. 132-6.2(e)).

4. Exceptions that make records confidential include:

    a. Certain law enforcement records (G.S. 132-1.4(a)).
    b. An attorney's written communications when the attorney is representing the agency (G.S. 132-1.1(a)). However, these communications must be regarding actual or potential legal claims and in the scope of the attorney's duty.
    c. Information about employees and applications for employment (G.S. 126-22).
    d. Settlement documents from suits or arbitration in which any State agency is a party and documents are ordered sealed by the court (G.S. 132-1.3(b)).
    e. Other records made confidential by law.

5. Environmental Health has the responsibility of separating any confidential information from otherwise accessible public records. Access cannot be denied to an entire file if only part of the record has confidential information (G.S. 132-6(c)).

6. Anyone who is denied access to public records may seek a court action to compel the State agency to turn over records (G.S. 132-9(a)). In the court action, the State agency has the burden at trial to show the record was confidential (G.S. 132-9(b)). The presumption is that all State records should be open to the public.

7. No person may destroy, sell, loan, or otherwise dispose of Public Records unless it is done in accordance with the "Records and Disposition Schedule" for County and District Health Departments issued by Department of Cultural Resources or under approved procedures (G.S. 132-3(a) and G. S. 121-5(b)).

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLANDESTINE METH LAB DECONTAMINATION

DATE DEVELOPED: **10/16**
REVIEWED: **6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED:

I. POLICY:

Clandestine meth lab decontamination documentation submitted to local health department (LHD).

II. PURPOSE:

To assure G.S. 130A-284, decontamination of property used for the manufacture of methamphetamine, is fulfilled by working closely with law enforcement.

III. GUIDELINES:

A. Law enforcement informs Environmental Health when a clandestine methamphetamine laboratory has been found within 24 hours of discovery.

B. Environmental Health or law enforcement posts notice signifying that the property has been used as a clandestine methamphetamine laboratory by the next business day.

C. Environmental Health notifies the property owner or his agent (the responsible party) that the property has been used as a methamphetamine laboratory, informs him that the property must be vacated, and informs him of the requirement placed upon a responsible party to remediate the property in accordance with the rules established in 10A NCAC 41D-Methamphetamine Decontamination prior to the property being reoccupied.

D. Environmental Health notifies the responsible party that a pre-decontamination assessment must be completed within 30 days of notice using the Pre-Decontamination Assessment template provided by NC Occupational & Environmental Epidemiology or equivalent.

E. Documentation of the pre-decontamination assessment must be provided to the LHD to be retained for three years.

F. Once decontamination is performed, the responsible party provides a copy of the decontamination activity to the LHD who reviews the documentation to determine the responsible party has documented activities addressing all requirements of the rules. The LHD notifies the responsible party in writing if it determines that the documentation is incomplete. The LHD retains the documentation for three years.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: INVESTIGATION OF FOODBORNE PATHOGENS

DATE DEVELOPED: 10/05
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 10/21; 6/22; 6/23; 6/24
REVISED: 6/17; 10/21; 6/22; 6/23; 6/24

I. POLICY:

Reportable foodborne disease cases are investigated by the Division of Public Health's Communicable Disease Coordinator in coordination with Environmental Health.

II. PURPOSE:

To prevent the spread of foodborne communicable diseases.

III. GUIDELINES:

A. Reports of a possible food-related illness are made to the Communicable Disease Coordinator.

B. For cases that are suspected to involve regulated establishments:

1. Environmental Health enters a complaint into CDP.

2. The Environmental Health Specialist (EHS) investigates the complaint by discussing the complaint with the person in charge and conducting a routine inspection, if it is due.

3. If more complaints are filed, repeat steps 1 and 2.

C. When the same symptoms are reported and a specific location is implicated:

1. The EHS will interview the person in charge to obtain:

   a. Food preparation histories, preferably from the preparing staff and confirm the available menu available to the ill group.
   b. Information about staff illnesses, absences, and resignations.
   c. Samples of leftovers, water, and ice, if available.

2. The EHS will implement controls based on the results of the investigation.

D. The Communicable Disease Coordinator will complete the investigation in the North Carolina Electronic Disease Surveillance System (NCEDSS) and attach any documentation required by the Communicable Disease Manual.

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NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Public Health

Environmental Health Section Foodborne Outbreak Response Guidelines



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Appendix

North Carolina Environmental Health Section Foodborne Outbreak Response Guidelines

This guideline provides comprehensive information about outbreak investigation from the Council to Improve Foodborne Outbreak Response (CIFOR) and reliable sources to help local and state health agencies mitigate the spread of foodborne illnesses and take actions to protect the public.

Foodborne Illness General Information

- Despite continuous preventive measures, foodborne illness is still a significant public health threat in the United States that warrants prompt and immediate attention by the local health department (LHD).
- According to Centers for Disease Control and Prevention (CDC), Norovirus causes 19-21 million illnesses each year, 56,000-71,000 hospitalizations and 570-800 deaths annually.
- CDC data shows that Norovirus is a very contagious virus that causes 58% of foodborne illnesses within the United States causing diarrhea, vomiting, nausea, and stomach pain.
- Norovirus outbreaks occur year-round but are most common from November to April.

I. Standard Operating Procedure (SOP) and Epi Kit

It is practical to have an informed investigative team that is trained and experienced in carrying out the basic functions in place before a foodborne illness is reported. In the event of an outbreak, a ***standard operating outbreak procedure*** (SOP) should be available, including food sampling guidelines to help avoid any unnecessary confusion, and to help guide the investigative team with duties and responsibilities. Review the SOP on a scheduled routine basis to ensure team members are aware of their roles and that communication remains clear and open. Before the investigative team heads into the field, an ***epi kit*** with equipment and forms should be on hand and ready to go. At a minimum, the foodborne illness outbreak epi kit should contain the following items:

- ***Pens/Paper/Pencil***
- ***Investigation guidelines***
- ***Investigative forms***
- ***Foodborne illness standard questionnaires and templates***
- ***Properly calibrated temperature-measuring device***
- ***Agency and laboratory phone numbers and contacts***
- ***Disinfection and sterilizing agents***
- ***Alcohol swabs***
- ***Hand sanitizer***
- ***Sterile specimen containers (unexpired)****
- ***Sterile wrapped sampling spoons****
- ***Large cooler/ Blue ice packs***
- ***Sterile gloves***
- ***Nonsterile zip-lock bags***

**Or have access to specimen collection materials through agreement with lab or other arrangement*

In addition to maintaining the SOP and epi kit, it is also important to consider the following prior to an outbreak:

- ✓ ***Make*** yourself knowledgeable about the most common foodborne illnesses and pathogens by including a library of information on enteric diseases and foodborne references.
- ✓ ***Identify*** a team leader who is an effective communicator and works well with others.
- ✓ ***Establish*** and implement a manual for outbreak investigations for the office that includes an easy-to-read flow chart on procedures and contact information of other agencies likely to be involved.
- ✓ ***Communicate*** and ***coordinate*** with other agencies to establish contacts in advance of a potential outbreak.
- ✓ ***Consult*** in advance with individuals in the laboratory concerning protocols for collecting, shipping, labeling, and other details of food and human biological samples.

II. Overview of a Foodborne Illness Outbreak and Response

A series of events occurs before public health officials can report that an illness case is linked to an outbreak. Foodborne illness concerns or food-related complaints are often reported directly to the health department via phone call, fax, or e-mail. The CDC developed the 7-steps to an outbreak investigation as an effective multifaceted approach to investigating foodborne outbreak. Foodborne illness investigations are often dynamic, and several steps to the investigation may occur at the same time as shown in **Figure 1.** By identifying the source of the outbreak, control measures can be implemented to prevent further spread of the illness as well as proper documentation and after-action meetings to identify areas for improvement, enhance future interactions with the epidemiology (Epi) team, and promote long-term compliance with risk factors.

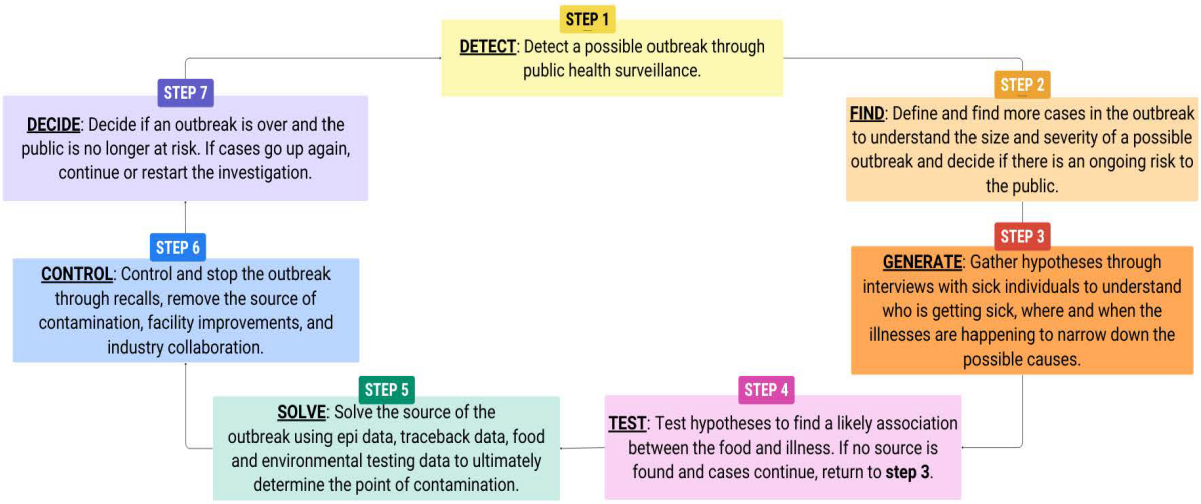

Figure 1. *7-Steps in a foodborne outbreak investigation*

III. P.I.E. the Escalation and De-escalation

It is necessary to develop and maintain a foodborne outbreak contingency plan to implement all parts of the investigation team's plans and procedures. The plan should include all criteria that have been identified that would trigger excess use of resources and identify resources that are available for quick access or for when an outbreak extends for a long duration. Finally, the plan should also expand on the established memorandums, procedures, communication strategies, foodborne illness outbreak protocols, as well as the agencies involved with their current contact information. Additional measures for improving performance are shown in **Figure 2** to thoroughly define actions that each stakeholder can take to prepare for a foodborne outbreak.

Prepare	Identify	Establish
Ensure foodborne outbreak investigation team plans and procedures are updated regularly.	Determine jurisdiction due to investigations requiring management in multiple jurisdictions.	Establish Memorandums, Mutual Aid, and other agreements.
Plan and coordinate with all other agencies that may be drawn into the investigation and response over time.	Identify criteria (triggers) used to provide excessive usage of agency resources.	Establish agencies involved in foodborne illness outbreak investigation
Plan and implement trainings from the Incident Command System (ICS) principles, and assist in obtaining supplies and equipment.	Identify useful resources for developing relationships and plans to facilitate quick access to these resources should the need arise.	Establish contact list with those involved within the foodborne outbreak investigation

Figure 2. *Foodborne Outbreak Escalation and De-escalation Practices*

IV. Communication and Information Sharing

Maintaining open communication and sharing of information for public health–related events are important. Open communication can also help prevent misinformation, rumors, and panic during an outbreak. Because foodborne illnesses often cross jurisdictional boundaries, it is important to establish relationships with key stakeholders in other cities, county, regional, and state agencies beforehand. For this reason, CDC's Epidemic Information Exchange (Epi-X) serves as a tool that provides rapid communication that connects public health professionals whenever there is a need to exchange preliminary information and respond to health threats. Local Health Departments can also use other reliable communication channels, such as websites, social media, newsletters, press releases, and meetings to disseminate information.

V. Local Health Department Roles

Local health departments (LHDs) must anticipate the need to rapidly expand after receiving and responding to complaints of illness directly from the public. Foodborne outbreak investigations are conducted through collaboration between public health staff from Communicable Disease, Public Health Laboratory, and Environmental Health (EH) disciplines as specified within **Figure 3**. The Communicable Disease team will likely involve public health nurses, communicable disease investigators, and epidemiologists. This group takes the lead in interviewing cases and their contacts, collecting patient data from health care providers and hospitals, while analyzing and interpreting epidemiological data. They also collect and analyze data or collaborate with a statistician.

Environmental Health Specialists (EHS) inspect physical facilities such as restaurants that may be involved in the investigation, interview staff at those facilities, gather information about commercial products and how foods are prepared and handled at a restaurant or other food facility, and obtain samples for testing. Environmental Health Departments may receive the initial illness complaints from restaurant patrons. EH also works with the food establishment on any cleaning, maintenance, or other control measures that are needed during the outbreak. Personnel from the public health laboratory, usually including microbiologists and laboratory technicians analyze both environmental and microbiological specimens collected from food, water, and people. These divisions work hand in hand through collaborations, coordination, and communication with each other, as well as other public health partners within the state and federal levels to mitigate risks associated with foodborne outbreaks and eventually conduct after-action reviews to improve investigation effectiveness and prevent future outbreaks from the same causes.

Environmental Health (EH) Services	Communicable Diseases / Epidemiology	Public Health Laboratory
• Investigates foodborne illness complaints. • Performs environmental investigations to identify contributing factors, including evaluating food preparation practices, observing food flow procedures, and collecting documents on sources of food for traceback. • Assists in identification and interview of ill food handlers. • Collects food and environmental samples. • Provides education to food establishment management and staff on topics including safe food handling and storage, proper cleaning and disinfection, monitoring ill employees and sick leave, and proper documentation of establishment procedures.	• Performs epidemiological investigations to identify the etiologic agent, persons at risk, size and scope, mode of transmission, and source of the outbreak. • Conducts disease surveillance. • Restricts ill food handlers. • Collects human specimens, as needed. • Informs the public, media, and healthcare providers, as needed.	• Provides guidance on collection, storage, and shipment of patient specimens and food/environmental samples. • Performs laboratory analyses of patient specimens and food/environmental samples. • Helps interpret test results

Figure 3. *Local Health Department roles and responsibilities*

VI. State and Federal Agencies

A foodborne disease outbreak may be managed solely by one local agency or may become the shared responsibility of multiple local, state, and federal agencies. Factors of the outbreak, including the type of pathogen, number and location of affected people, geographic jurisdictions involved, and local and state food safety rules and laws, will determine the types of agencies that need to be involved. The state agencies within the North Carolina Department of Health and Human Services, Division of Public Health involved in foodborne outbreak investigations are, but not limited to:

1. **Environmental Health Section** – protects people by promoting a safe and healthy environment in partnership with private businesses and public agencies through consistent application of education, best practices, and compliance monitoring.
2. **Public Health Preparedness and Response** – provides aid in major emergency response operations such as natural disasters, intentional contamination, and any outbreak or response requiring deployment of resources.
3. **Communicable Disease Branch** – provides routine surveillance of diseases, assists in investigating outbreaks, and assists in communication sharing between local, state, and federal public health agencies, private physicians, and hospital and occupational infection control personnel.

State, local public health, and agriculture partners work closely with CDC during multistate outbreak investigations. Some of their tasks, which are essential for the investigation are to:

- ***Interview*** people about the foods they ate before getting sick.
- ***Collect*** food from sick people's homes or stores for testing.
- ***Conduct*** traceback to identify where the contaminated food came from.

VII. Outbreak and Control Team

Once a foodborne outbreak is confirmed, it is vital that the key personnel of an outbreak investigation and control team are involved. An outbreak investigation and control team within North Carolina will consist of a Team Lead, Epidemiologist, Environmental Health Specialists, *Laboratory/ North Carolina Department of Agriculture & Consumer Services (NCDA) as needed,* and Public Information Officer as shown in **Figure 4**. The core team should be involved in all outbreak investigation, serving as the focal point for organizing multidisciplinary and/or multiagency tasks, and enabling the development of effective working relationships with external partners and advanced expertise among staff. The core team will also develop a case definition to determine which individuals will be included in the outbreak. Anytime more than one group is involved in working on an outbreak investigation, the investigation becomes more complicated, and communication becomes even more important.

If the source of contamination occurs prior to the point of retail food preparation (e.g. manufacturer, supplier, distributor, etc.), the North Carolina Department of Agriculture and Consumer Services (NCDA & CS) has investigative jurisdiction. The NCDA & CS may also collaborate with the US Department of Agriculture (USDA)-Food Safety and Inspection Services (FSIS) and/or the US Food and Drug Administration (FDA). As the outbreak investigation and control team members compile detailed data and information gathered from the outbreak, the team should be able to identify what went wrong to ensure that future similar events can be prevented. Other entities from the local and state agencies can be brought in to identify the source(s) of the exposure so that public health action can be taken to establish control measures that can mitigate the spread of disease.

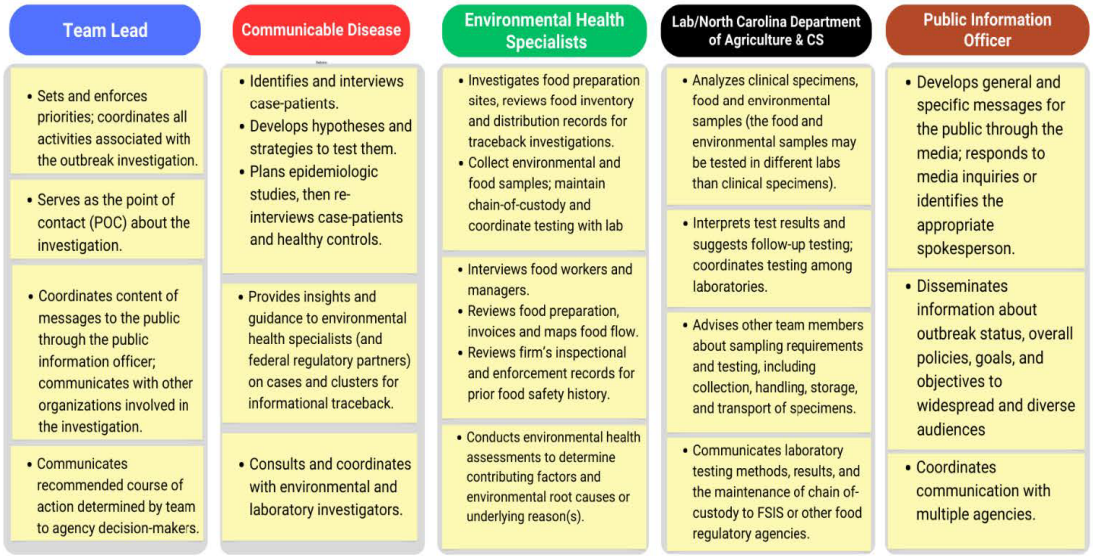

Figure 4. *Outbreak Investigation and Control Team*

VIII. The 10-Step Approach to Outbreak Investigations

Epidemiologists use an organized, multistep approach to field investigations. Although the steps illustrated in **Figure 5** are in numeric order, they might be conducted out of order or at the same time to meet the demands of the investigation. The first step of identification of the investigation team and resources may include the local epidemiology teams, state communicable disease branch epidemiologist/subject matter experts, nurse consultants, Public Health Emergency Response Strike (PHRST) teams, disease investigation specialists (DIS), UNC Epi-Aid, CDC, and many others. Step two is the confirmation or verification of the diagnosis to the extent possible, addressing the problem that was reported initially and ruling out misdiagnosis and potential laboratory error. Step 3 is the determination of the existence of an outbreak. This step is often a difficult step that should be completed before committing program resources to a full-scale investigation. To confirm the existence of an outbreak, the field investigation team must first compare the number of cases during the suspected outbreak period with the number of cases that would be expected during a non-outbreak timeframe.

The goal of creating case definition within step 4 is to identify, or establish, as many cases as possible without including non-cases. Step 5 then arranges and positions the data in terms of time, place, and person. By doing so, the data translates from the line listing into a basic epidemiologic explanation of the outbreak. This description, often referred to as descriptive epidemiology, describes the outbreak in terms of time, place, and person (an in-depth explanation provided within the next section). Step 6 considers whether control measures can be implemented. In concept, control measures are implemented only after the preceding and subsequent steps—including developing and testing hypotheses about the cause or mode of spread—have been implemented. Control measures should be considered again after more systematic studies are complete.

As the process continues, step 7 expands on how to develop and test hypotheses about the disease-causing agent, source or reservoir of the agent, transmission mode, and risk factors for diseases based on descriptive epidemiologic findings resulting from analysis of the line listing of identified affected patrons, information obtained from interviews of individuals or groups of affected people using structured questionnaires or open-ended questioning. Step 8 expands on implanting controls and preventative measures. At this stage of most epidemiologic field investigations, the purposes of systematic or other studies might include improving the quality numerators or denominators causing the investigation's conclusions about the problem. Evaluating the impact of control measures is essential; therefore, step 9 communicates the findings for implementing and evaluating control and prevention measures. The information provided helps keep the public and stakeholders informed as well as provides informed decisions about actions to stop the outbreak, and documentation of the investigation. The final step is to maintain surveillance to prevent additional outbreak-associated with disease or death.

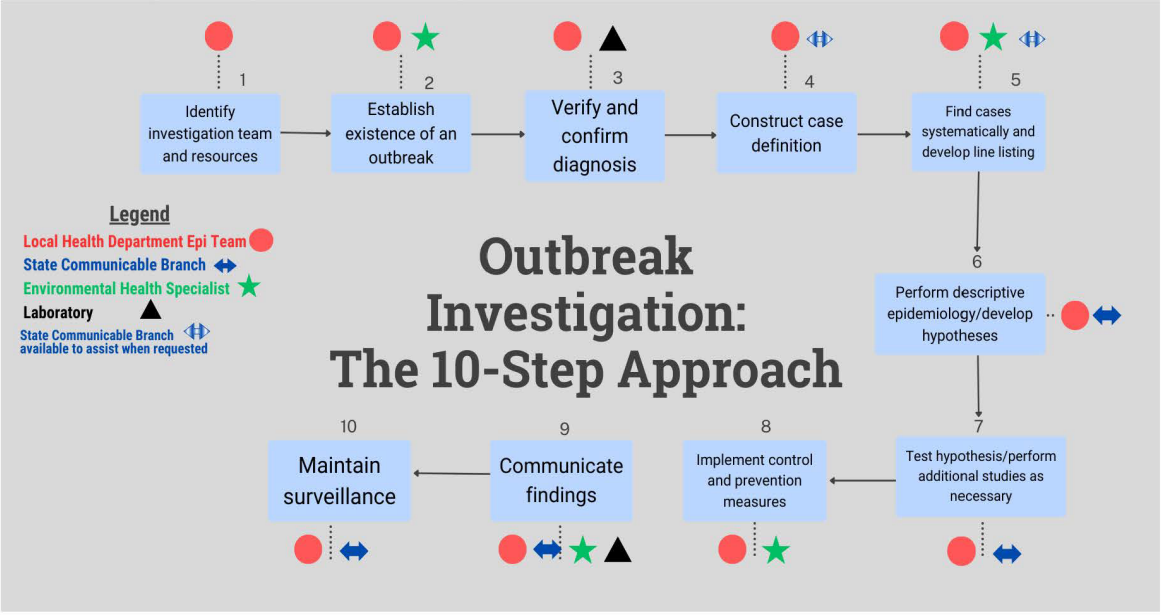

Figure 5. *Outbreak Investigation: The 10-Step Approach*

IX. Investigation Description and Analysis

It is important to establish that the outbreak is real by examining how the cases were diagnosed and by determining what the baseline rate of disease was previously. An effective outbreak investigation describes the who, where, and what of a foodborne outbreak. The ***who*** can describe the age, gender, race, clinical signs, symptoms, and asks how many cases and death have occurred. Finding sick people associated with the outbreak is important to help public health officials understand the size and seriousness of a possible multistate outbreak and decide if there are ongoing risks to the public. After determining the ***who***, it is important to describe the ***where***. The ***where*** can help in determining the epidemiological profile of an area to verify the extent of the outbreak (i.e., park, restaurant, school, etc.).

With the descriptive epidemiology and through systematic review of data in the line listing, key actions typically involved are drawing the epidemic curves, constructing spot maps or other special spatial projections, and comparing groups of people. These key actions contribute to developing initial hypotheses for explaining the potential cause, source, and mode of spread of the outbreak's causative agent(s). Establishing the time of the outbreak or epidemic requires collecting information about key events identified during the creation of the line listing or through other inquiry, including the time of onset of illness (symptoms, signs, or laboratory test positivity) among affected people; period of likely exposure to the causal agent(s) or risk factor(s); time when treatments were administered or control measures were implemented; and time of potentially related events or unusual exposures. The information collected is used to describe the demographic characteristics (e.g., age, sex, and race/ethnicity), occupation, diagnoses, and features shared by affected patrons to develop preliminary estimates of rates of illness in relation to demographic, exposure, and other characteristics. Additional outbreak information infographic questions obtained from the World Health Organization (WHO) in **Figure 6** should be considered to assist in describing and analyzing the outbreak.

Figure 6. *World Health Organization's outbreak infographics*[1]

X. Verify and Confirm Diagnosis

One of the first tasks that should be considered before heading into the field is to verify the existence of the outbreak. This is done by gathering information and verifying the diagnosis of clinical findings of any reported cases through hospitals, laboratories, physicians, or other reports. This is important to ensure the disease has been properly identified and rule out laboratory error as the basis for the increase in reported cases.

To confirm the diagnosis, it is important that the individual making the reported complaint be interviewed. The data and information gathered from the interview process are critical as they provide the ideal opportunity to identify a common location or activity. The interview also provides the chance to get the list of items that the individual was exposed to and an estimate incubation period. This can be done either over the phone or by talking directly face to face with those involved in the outbreak. The interview is critical to helping provide clues to the clinical descriptions of the illness and useful for developing the hypotheses. It can help answer questions about exposure and what could have caused the illness or help with finding other individuals that may have been exposed as well.

XI. Environmental Health Specialist (EHS)

Verifying a situation is a collaborative effort, and it is not an effort that should be performed alone because it requires a lot of input from a variety of sources. The EHS works in collaboration with many partners to determine the existence of an outbreak, find cases, identify the cause, and implement control measures. The main responsibilities of the EH investigation rest firmly on the EHS and that person's knowledge of food safety and control measures needed to facilitate the prevention and spread of further illness. Although the relevant roles of an EHS may vary by scenario, these investigations typically involve the following:

- ***Describe*** the suspected food agent.
- ***Observe*** food handling procedures that may have contributed to contamination of the suspected food agent.
- ***Interview*** food workers and managers.
- ***Take*** temperatures of food storage devices and other relevant measurements
- ***Create*** a food flow chart for the suspected food agent, including details about storage, preparation, cooking, cooling, reheating, and service to identify opportunities for contamination, survival, and proliferation of pathogens.
- ***Collect*** specimens from food, the food handling environment, or people in contact with the suspected food agent.
- ***Collect*** and ***review*** invoices or other documents describing the source of the suspected food agent.

XII. Environmental Health (EH) Assessments

Environmental health assessments are an important part of outbreak investigations. Food safety programs can use environmental assessments to respond to outbreaks of foodborne illness and make recommendations for prevention. Environmental Health Specialists usually conduct assessments by evaluating the food safety system to understand and address what happened to cause the outbreak and the root causes of the outbreak through engagements with epidemiologist and laboratory to assess all aspects of the food safety system. Through it all, the primary goal of an EH assessment at a food establishment is to identify the source of illness and prevent further illness by identifying and removing contaminated products from distribution/sale, identifying, and correcting improper food handling, food production, food storage, and employee health practices, as well as developing and improving food safety procedures and policies.

XIII. Conducting the Field Investigation

Environmental field investigation should be performed if the epidemiological investigation suggests a common source exposure such as consumption of food or water at a particular food service establishment or gathering. The exposure, onset of symptoms, and risk factors associated with the illness and other known data, collected by the local EPI Team or Communicable Disease Nurse may help develop an initial hypothesis. The Communicable Disease Branch (CD Branch) and Division of Public Health may assist the local health department with the epidemiological investigation of the outbreak and conduct further studies if necessary. The State Laboratory of Public Health (SLPH) may test clinical samples from ill individuals associated with the outbreak for detection of suspected microorganisms.

During the field investigation, it is critical to interview patrons who are ill, as well as those who were not. Information obtained from patrons during the investigation may include:

- ✓ ***Collecting*** information related to demographics, signs, and symptoms. Utilize hospital records and laboratory records when possible.
- ✓ ***Gathering*** data about all foods, water, and ice consumed within the past 72 hours that preceded the illness.
- ✓ ***Determining*** the illness history including when the illness started, and associated signs and symptoms.
- ✓ ***Obtaining*** any clinical specimens and food specimens where possible. Stool samples may be requested from ill patrons to identify the outbreak causing pathogen.
  - *If food samples are available, collect, label, and hold in refrigeration.*
  - *If a commercial product is suspected, gather the original container or package. This can be used to track a lot of numbers for tracing back to the processor.*

As the investigation continues, it is important to maintain communication with other team members including the laboratory, to ensure that they are aware of the proper protocol for mailing specimens of the collected food or biological samples.

XIV. Control Measures

Preventing the further spread of the illness should be the top priority of any investigation. Effective surveillance to track cases of foodborne illness and outbreaks is critical to developing useful control strategies, especially early in the investigation to reduce the possibility for new illnesses. Nonspecific control measures can be implemented when a facility has been implicated in an outbreak, but a specific food has not been identified. Pathogen-specific control measures should be taken once the pathogen has been identified.

A. Cleaning and Sanitizing

Before cleaning begins, ensure that personal protective equipment (PPE) is safely donned (slipped on) and doffed (removed). Anyone cleaning up vomit or diarrhea should wear single-use gloves and a face mask with effective covering. The use of improper chemicals on food contact surfaces can lead to chemical contamination of food products and may result in food contact surfaces that are not sanitized or disinfected properly. Examine the products used to clean and sanitize to ensure that they are approved for use on food contact surfaces. Verify the strength of sanitizing solutions and ensure that employees are knowledgeable on the proper strength and mixing ratio. Examine cleaning records and/or schedules if available.

B. Surface Clean-Up

Special attention should be given to food contact surfaces and high hand contact surfaces when someone vomits or experiences diarrhea in the establishment (Table 1). Unless environmental samples are needed for laboratory testing, surfaces should be cleaned and disinfected immediately to prevent the possibility of cross contamination.

Hard Surfaces	Carpet and Upholstered Furniture	Linen, Towels, and Clothing
Step 1. COVER • Cover the vomit or diarrhea with paper towels or an absorbent powder (cat litter) **Step 2. REMOVE** • Remove the soaked paper towels or hardened powder with a scoop/scraper and carefully place them in a plastic **Step 3. WASH** • Prepare a solution of soapy water. • Wash all surfaces contaminated with vomit or diarrhea with the soapy solution. • Rinse the soapy water from all surfaces **Step 4. DISINFECT** • Use paper towels or a mop with a washable or disposable mop head to wet all washed surfaces with disinfectant. • Rinse all food-contact surfaces with clean water after they have been disinfected. • Wash, rinse, and sanitize these surfaces prior to using for food preparation.	**Step 1. COVER** • Cover the vomit or diarrhea with paper towels **or** an absorbent powder (cat litter) to soak up liquids. **Step 2. REMOVE** • Carefully remove the saturated paper towels or hardened powder with the scoop/scrapper and place in a plastic bag. • **NEVER** vacuum. **Step 3. WASH** • Prepare a solution of soapy water. • Wash all surfaces contaminated with vomit or diarrhea with the soapy solution. • Rinse the soapy water from surfaces with clean water. **Step 4. DISINFECT** • Steam clean the area for 5 minutes at 170°F (76.7°C) (Not all steam cleaners can reach a temperature of 170°F (76.7°C), so check the manufacturer's specs). • Upholstered furniture that is soiled with vomit or diarrhe can be disinfected with a bleach solution, however the bleach will discolor the material.	**Step 1. CONTAIN** • Carefully place all washable contaminated items in a disposable bag to be laundered. **Step 2. WASH** • Machine wash soiled items in a washing machine using hot water, laundry detergent and disinfectant. • Wash with an effective disinfectant, bleach, or other chemical. **Step 3. DRY** • Dry freshly-washed items in a dryer on the high-heat setting.

Table 1. *Vomit & Diarrhea Surface Clean-up Plan*

C. After Clean Up

Remove

- Remove all PPE and place in the plastic bag.
- Do not touch surfaces that were just cleaned as they can be re-contaminated.
- After completing disinfection, close off the area for at least one hour when possible
- All PPE must be taken off before leaving the area that has just been cleaned.
- Place all used cleaning supplies in the plastic bag.
- Seal the bag with a twist tie or other effective method.
- Throw away all uncovered food in the contained area, as well as any food handled by the person who was sick.
- Remove all waste from the facility immediately following local, state, or federal rules.

Cleaning Mops & Scoops

- Wash and disinfect mop handles and other reusable cleaning supplies, such as scoops/scrapers, using the same steps used for hard surfaces (see **Table 1**).

Wash Hands

- Wash hands thoroughly before performing any other duties (food-handlers should double-wash hands).

D. Employee Health

The level of knowledge and practical application of policies that address ill employees will directly impact the potential for employee health-related outbreaks. Establishments that practice a proactive approach on open disclosure of illnesses and voluntary exclusion/restriction are better able to prevent employee health related outbreaks. Evaluate the Person in Charge's (PIC) knowledge of procedures and the events that occurred during the period leading to the outbreak using open-ended questions to obtain the information.

If the suspected pathogen is from a human source via the fecal-oral route (e.g. viral), such as norovirus, it is important to question the manager and employees about the health of the employees during the time prior to the outbreak. If an ill employee has prepared food products, the food must not be served. If samples are not needed for analysis, then the food should be discarded. Employees with active diarrhea, vomiting, or sore throat with fever have the potential to contaminate food and environmental surfaces with bacterial and viral particles. Pay close attention to the employees present during the investigation and note signs of possible illness, such as jaundice, flushed appearance, and multiple trips to the restroom. Observe hygiene practices of the employees, such as handwashing, general appearance, and the handling of ready-to-eat foods with bare hands. Proper handwashing and refraining from bare hand contact with ready-to-eat foods are important control measures during foodborne illness outbreaks. Food service employees with gastrointestinal symptoms (e.g. nausea, vomiting, diarrhea, stomach cramps) should be excluded from the food service establishment until symptomless for at least 48 hours, or until the employees have been cleared to return to work by a medical practitioner.

XV. Public Health Legal Preparedness

Food establishments should be prepared to address both regulatory requirements and the way these requirements might affect their internal policies on sharing information. Both public and private entities should be included in foodborne illness exercises to test their understanding of their legal authority and duties related to outbreaks. The adequacy of local and state legal preparedness for foodborne illness outbreaks should also be evaluated regularly through exercises and after-action reviews from actual outbreaks. As part of ensuring the jurisdictions' legal preparedness, local and state officials should at minimum follow the steps shown in **Figure 7** when consulting with their legal counsel. All states and territories have legal requirements for the reporting of certain illnesses and conditions, including illnesses likely to be foodborne (e.g., salmonellosis, campylobacteriosis, and STEC infection), by healthcare providers and laboratories to the local, state, or territorial public health agencies. **** If you do not understand or disagree with the advice provided by your agency's attorney, it is best to ask for clarification or discuss other options with him or her rather than requesting different advice from another attorney.***

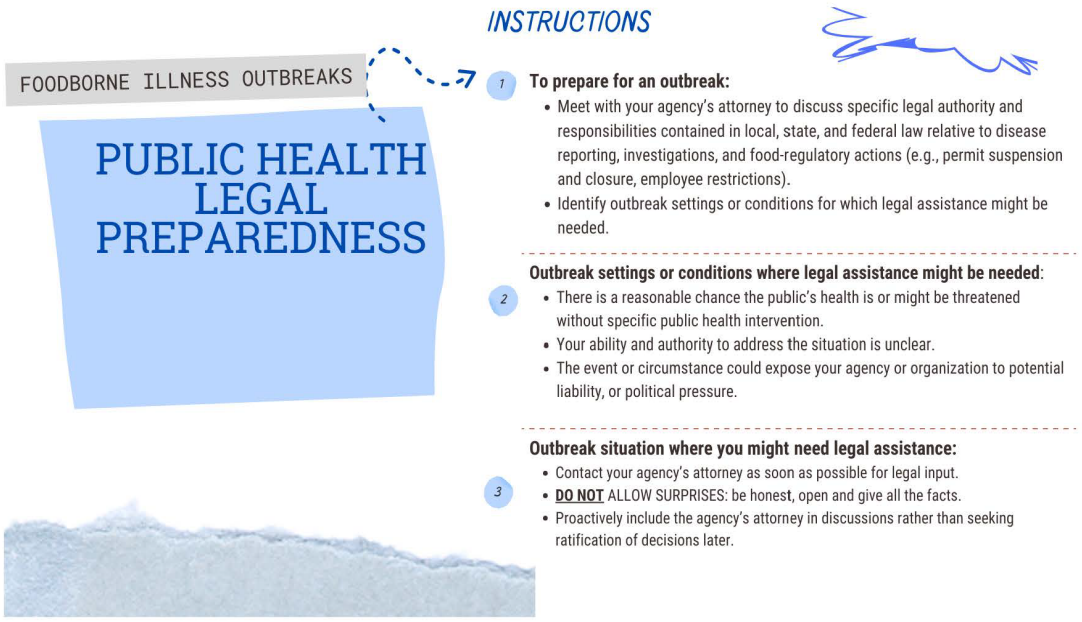

Figure 7. *Public Health Legal Actions*

XVI. After-Action Meeting

An after-action meeting is used to bring together the core players in the investigation (Environmental Health staff, the EPI Team, the State Communicable Disease Staff, and others) for a last review of the procedures, conclusions, control measures, and documentation. The Environmental Health staff can provide beneficial input into the practicality of procedures used during the investigation and offer opportunities for improvements. Discussion of the investigation provides a learning opportunity for less experienced staff and can identify future educational needs for food service establishments.

A review of the field investigation with the EPI team can lead to improvements in team procedures that better utilize time and resources for future investigations. Also consider disseminating the knowledge with the Local Health Department. Educating Health Department leadership on the efforts that go into the prevention and control of foodborne illnesses shows the value of foodborne illness investigations and may result in future support in funding and resources. Finally, meet with the manager and responsible employee(s) of the food service establishment to ensure that proper procedures are being followed. Address any concerns they may have with the implementation of the risk control plan or other procedures instructed earlier. Every outbreak will differ per occurrence; therefore, adjust the plan or procedures as necessary.

XVII. Summary

Foodborne illness outbreaks are complex and rapidly evolving situations that require quick response to reduce additional illnesses. There are multiple partners involved in outbreak investigations, including state, federal, and local regulatory authorities. Local EPI teams work to confirm the diagnosis and identify cases to develop a hypothesis. Environmental Health Specialists assist in interviewing food workers, conducting environmental assessments, and helping to implement control measures. All partners must work together to solve outbreaks and determine contributing factors to reducing chances of recurring outbreaks.

XVIII. Resources

(1) Outbreak Toolkit. World Health Organization. Retrieved April 2024, from https://www.who.int/emergencies/outbreak-toolkit

CIFOR Toolkit. Council to Improve Foodborne Outbreak Response. Retrieved April 2024, from https://cifor.us/products/toolkit

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When a GI Illness/Norovirus Outbreak is Suspected

First steps - after two unrelated illness complaints are received with a common meal source, and further investigation is determined to be needed by Local Health Department(LHD)

- ☑ *Contact Local Communicable Disease, Epi Team, State Environmental Health Outbreak Coordinator/Regional Specialists*
- ☑ *Document complaint using internal/county policy and complaint system (DHD, CDP, etc), conduct complainant interview*
- ☑ *Obtain 72 hour food history, and information on any ill household, work or school contacts and specific information on suspect meal, including how it was ordered (dine-in, take out, delivery) and if anyone else reports being ill*

Environmental Field Investigation

Front of the House	Where are there common touch surfaces (door handles, ordering kiosks, menus, counters, self service areas, etc.)? How are these cleaned/disinfected? What is the cleaning/sanitizing process for table service items such as salt/pepper shakers, chip baskets, ketchup bottles, soy sauce bottles, etc.?
Employee Health and Hygiene	Have any employees reported symptoms of nausea, vomiting or diarrhea in the last 48 hours? Have any household contacts been sick with vomiting/diarrhea? What is the facility's employee health policy? What documentation is available? Are proper handwashing practices observed? Do sinks have supplies (Soap, paper towels)? Are handwashing sinks accessible? What is the glove policy? Is there any bare hand contact with ready to eat food?
Vomit/Diarrhea Cleanup and Restrooms	Does the facility have a written vomit/diarrhea cleanup plan? Kit available? Have there been any reported vomit or diarrheal events in the facility recently? Which employees are responsible for vomit/diarrheal cleanup, how do they ensure no cross contamination when performing other job duties, how do they monitor their health after a cleanup event?
Food Contact Surfaces	What sanitizer is used for food contact surfaces, is it being used at proper concentrations? If warewashing machines are used, are they operating properly? Are food service utensils (multi-use and single service) stored and handled in a manner to prevent potential contamination?
Food Sources and Service	Were any shellfish consumed? What is the source/tag information? Were there frozen berries consumed? Other high risk or recalled foods involved? Are there opportunities during food preparation for cross contamination?

During the field investigation, all other risk factors can be observed. However, they should not be the primary focus, as processes such as final cook temperatures, cooling, cold/hot holding, date marking, etc. are less likely to be the contributing factor in a norovirus outbreak.

Follow-up - After Field Investigation

- ☑ *Document field investigation visits following internal/county policy, and using facility visit sheets. Contact State Environmental Health Section for consultation before suspension/voluntary closure*
- ☑ *Recommend switching to chlorine bleach disinfectant for high touch surfaces, bathroom cleanup, and disinfectant (1000-5000 ppm) Dilute regular, unscented bleach 1:10 ratio *can use 1/3 cup bleach in 3/4 gallon water**
- ☑ *Additional recommendations: linen should be cleaned using a pre-wash cycle, and hottest available water and dryer cycle; carpets and furniture should be steam cleaned to 170 F; recommend switch to single service utensils*
- ☑ *Ensure clear, specific control measures are provided in writing to establishment when deficiencies are found*

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Gather all partners (State Epi, State Environmental Health Section, Local Communicable Disease, Local EH, Public Information Officer, LHD, others) for conference call to discuss control measures and next steps

Each outbreak will be unique and should begin with menu review and food flow. Documentation of all activities is important. Contact Veronica Bryant, (919) 218-6943, veronica.bryant@dhhs.nc.gov for assistance.

When a Toxin Related Outbreak is Suspected

First steps - after two unrelated illness complaints are received with a common meal source, and further investigation is determined to be needed by Local Health Department(LHD)

- ✓ *Contact Local Communicable Disease, Epi Team, State Environmental Health Outbreak Coordinator/Regional Specialists*
- ✓ *Document complaint using internal/county policy and complaint system (DHD, CDP, etc), conduct complainant interview*
- ✓ *Obtain 72 hour food history, and information on any ill household, work or school contacts and specific information on suspect meal, including how it was ordered (dine-in, take out, delivery), and if there are leftovers to be sampled*

Environmental Field Investigation

Menu Review	How does the facility prepare foods that are commonly associated with toxin outbreaks (rice, cooked potatoes, gravy, soups/stews, etc.)? What is the food flow for the food or foods associated with the suspect meal? Are there opportunities for toxin formation during the process? (hot holding, cooling, reheating?)
Cooking and Reheating Procedures	What is the process for cooking foods from a raw state? Are thermometers being used to check cooking temperatures, and are any cooking logs being completed? Are all cooked foods served immediately/cooked to order? If previously cooked foods are reheated, what is the process for reheating? Are the foods reheated for immediate service or for hot holding? Are there any partial cooking or non continuous cooking procedures being followed?
Cooling Procedures	What is the process for cooling foods that have been cooked or held hot? Are thermometers being used to check cooling temperatures, and are any cooling logs being completed? Are there roasts, pork shoulders, or other food products that are cooled intact that may not cool properly due to thickness? How is food handled while being cooled? Is there any bare hand contact during cooling process?
Holding Temperatures	Does the facility hold food hot? How long are foods typically held hot? (meal service, full operational period, during a special event only, etc.) What is the food flow for the food or foods associated with the suspect meal? Are there opportunities for toxin formation during the process? (hot holding, cooling, reheating)?
Service and Serving Equipment	Does the facility serve hot meals on buffet, hot serving line, or for special events/banquets? What equipment is used for hot hot holding (sterno, cambro, mechanical)? What are the time periods of service? Are thermometers used? What is done with food at end of service period?

Follow-up - After Field Investigation

- ✓ *Document field investigation visits following internal/county policy, and using facility visit sheets. Contact State EH Section for consultation before suspension/voluntary closure*
- ✓ *Determine if any foods are available for food sampling, and if there is lab capacity to perform sampling. Coordination between State EH, State Epi, and often NCDA and/or federal partners must occur*
- ✓ *Control measures may include risk control plans for cooling, additional requirements for hot holding and service equipment when found to be insufficient. Recommend short serving periods and discarding leftovers during events.*
- ✓ *Ensure clear, specific control measures are provided in writing to establishment when deficiencies are found*

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health

Gather all partners (State Epi, State Environmental Health Section, Local Communicable Disease, Local EH, Public Information Officer, LHD, others) for conference call to discuss control measures and next steps

Each outbreak will be unique and should begin with menu review and food flow. Documentation of all activities is important. Contact Veronica Bryant, (919) 218-6943, veronica.bryant@dhhs.nc.gov for assistance.

Confirmed Vibrio Case Investigation

When a confirmed case of vibrio is reported to the Local Health Department, it is important to follow these steps to ensure each case is investigated quickly and that all partners are notified.

Investigation Steps

Interview the case	**Local Communicable Disease Nurse**
Complete the COVIS Form (Sections 1 - 4)	**Local Communicable Disease Nurse**
Complete Seafood Investigation (Section 5) of COVIS Form	**Local Environmental Health Specialist**
Forward shellfish information to NC Division of Marine Fisheries Shellfish Sanitation Inspectors	**State Environmental Health Section**
Return completed Seafood Investigation Form to Communicable Disease Nurse	**Local Environmental Health Specialist**
Attach all shellfish information, including any tag information provided into NCEDSS event	**Local Communicable Disease Nurse**
Provide shellfish information to CDC SEDRIC Reporting System	**State Communicable Disease Branch**
Coordinate with Federal partners on traceback investigations and seafood recalls	**State Environmental Health Section**

Resources

Cholera and Other Vibrio Illness Surveillance (COVIS) Report

The Cholera and Other *Vibrio* Illness Surveillance (COVIS) system is used for reporting human infections with pathogenic species of *Vibrionaceae*, which cause vibriosis and cholera. It captures a description of the person's illness with underlying health conditions, recent seafood consumption, recent exposure to bodies of water, and sources of implicated seafood.

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NCDEQ Division of Marine Fisheries Shellfish Sanitation & Recreational Water Quality

Shawn Nelson
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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PUBLIC HEALTH PEST AND VECTOR MANAGEMENT

DATE DEVELOPED: 11/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18; 6/20; 6/24

I. POLICY:

Mosquito, rodent, and pests of public health significance complaints are taken by the Environmental Health Section for investigation.

II. PURPOSE:

To prevent the spread of communicable diseases and seek removal of pest and vector breeding areas and harborage.

III. GUIDELINES:

A. Complaints about **vectors** and pests of public health significance are submitted to Environmental Health.

B. Investigation conducted by the assigned Environmental Health Specialist.

C. The Environmental Health Specialist inspects looking for areas of breeding and harborage.

D. **The Environmental Health Specialist recommends ways to remove** breeding conditions, breeding sites, and harborage areas **to the property owner**. When necessary, to require removal of an improper solid waste site, the site is referred to Solid Waste/Code Enforcement.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SOLID WASTE

DATE DEVELOPED: 12/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18; 6/22

I. POLICY:

Solid Waste inspections and solid waste complaint investigations are conducted in accordance with Rules and Regulations Governing the Storage, Collection, Transporting, and Disposal of Solid Waste in Rockingham County, North Carolina; Ordinance Establishing Regulations for the Proper and Lawful Management and Disposal of Solid Waste within Rockingham County There of; and through North Carolina General Statutes 130A-290-291, including .0102-.0108.

II. PURPOSE:

To prevent the spread of communicable diseases and provide for proper storage, removal, transportation and disposal of Solid Waste.

III. GUIDELINES:

A. Environmental Health and Solid Waste Enforcement Officers inspect solid waste handling and storage in manufactured home parks.

B. Solid Waste Enforcement Officers, duly-trained and sworn Deputy Sheriffs of the Rockingham County Sheriff's Department may issue citations including civil penalty fees, arrest warrants, and warnings without fines, answer complaints involving alleged improper handling, storage, and disposal of solid waste.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MANUFACTURED HOME PARKS

DATE DEVELOPED: 12/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/20; 6/22

I. POLICY:

Manufactured Home Parks are inspected annually in accordance with the Rockingham County Board of Health and Human Services Rules Governing the Sanitary Design, Construction, Alteration, Maintenance, Operation and use of Manufactured Home Parks in Rockingham County, North Carolina. These rules also require submission and approval of plans and specifications to the Department of Health and Humans Services for construction or alteration of a manufactured home park. Authority for the regulations is contained in Article 2, Chapter 130A-39(a) of the General Statutes of North Carolina. Inspections include the sewage systems, as required in Laws and Rules for Sewage Treatment, and Disposal Systems 15A NCAC 18A .1900; water supply and distribution systems, as required in 15A NCAC 02C .0100 - .0119, and GS 87-98 and 15A NCAC .0100, .0300, and 15A NCAC 18A .3800, and 15A NCAC 27; and 15A NCAC 18A .1700; solid waste, as required in the Rules and Regulations Governing the Storage, Collection, Transportation, and Disposal of Solid Waste in Rockingham County, North Carolina.

II. PURPOSE:

To protect public health and the environment, and prevent the spread of communicable diseases by regulation of the water supply, sewage disposal, and solid waste management in manufactured home parks.

III. GUIDELINES:

A. Annual inspections or surveys are conducted in manufactured home parks to determine compliance with well and water regulations, sewage disposal and solid waste management.

1. Wells are inspected to ensure wellhead protection and proper ventilation.

2. A water sample is collected at each manufactured home park that uses a well for drinking water for bacteriological analysis.

3. The locations of sewage or septic systems are observed after a review of system locations in each manufactured home park.

4. Solid Waste containers, disposal practices and cleanliness are observed to require cleanup of improperly stored solid waste, and maintenance of clean premises.

B. No improvement or expansion of a manufactured home park shall be approved until all requirements of the manufactured home park regulations are met.

C. Documentation shall be handled as follows:

1. The manufactured home park inspection form is completed.

2. A copy of the inspection form goes to the manufactured home park owner or manager, and a copy is retained on the manufactured home park record in TRAKiT along with the results of the water sample analysis by the NC Lab of Public Health in Raleigh.

3. The manufactured home form indicates corrections to be made and a violation notice may be issued for non-compliance. A copy of any violation notice is also retained on the manufactured home park record in TRAKiT. Violations are followed up with documentation of corrections.

4. TRAKiT software is used to record these inspections and results.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMPLAINTS AND ENFORCEMENT

DATE DEVELOPED: **1/06**
REVIEWED: **6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/17; 6/20; 6/23; 6/24**

I. POLICY:

Environmental Health investigates complaints received from the public.

II. PURPOSE:

To respond to public requests to investigate and remediate complaints involving potential or actual environmental problems in the community in a timely manner.

III. GUIDELINES:

A. Complaints may involve food, lodging and institutions; on-site wastewater; child care facilities; public swimming pools; tattoo facilities **and artists**; childhood lead prevention; migrant housing; private wells, well protection and water quality of regulated facilities; animal control and dangerous animals; manufactured home parks; hazardous materials and spills; and pest management.

B. Complaints are investigated to determine if there are violations of the law, rules, or local ordinances pertaining to the environmental programs listed in III. Guidelines, Section A. of this policy.

C. Initiation and resolution of a complaint:

1. A complainant files a complaint by contacting the Central Permitting Office, Environmental Health, or by using the form on the website.

2. The complaint is entered into CDP or TRAKiT and is assigned to an Environmental Health Specialist.

3. The Environmental Health Specialist shall investigate **each alleged complaint** by telephone and/or a visit. Effort will be made to investigate all complaints within fifteen (15) business days or as directed according to the nature of the complaint, the state statute, or availability of staff.

4. Each complaint is documented in CDP or TRAKiT.

D. Enforcement Procedure:

1. A Notice of Violation or letter of enforcement is issued, when necessary, for enforcement.

    a. The Notice of Violation or letter of enforcement shall cite the type of violation and law, rules, or ordinance section violated.
    b. A time limit shall be listed for the violation to be corrected or for a remedy to be completed.

2. A follow-up site visit will be made to determine:

    a. Any attempts made to correct the violation.
    b. Document the violation problems by discussion with the resident or property owner.
    c. Document the violation problems with notes, photographs or other evidence.

3. If the violation has not been resolved **or work done toward resolution**, the Environmental Health Specialist issues a follow-up notice of violation that requires a remedy within ten days and before legal action is taken.

4. A follow-up site visit will be made to determine:

    a. Any attempts made to correct the violation.
    b. Document the violation problems on the day of the latest visit.

5. If the initial Notice of Violations do not bring about compliance, the violation shall be turned over to the County Attorney.

    a. Documentation, photographs, or other evidence is presented to the County Legal Department.
    b. The County Legal Department may issue a further notice of violation with a deadline for legal action or proceed with legal action.
    c. The County Legal Department shall pursue any legal action required.

6. The court ruling will be followed to resolve and remedy the complaint.

E. If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MIGRANT HOUSING PREOCCUPANCY INSPECTIONS

DATE DEVELOPED: 1/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18; 6/20; 6/22; 6/23; 6/24

I. POLICY:

Migrant housing preoccupancy inspections are conducted as required under North Carolina General Statue 95 Article 19 - Migrant Housing Act of North Carolina.

II. PURPOSE:

A. To protect public health and ensure a clean, healthy environment for migrant farm workers, and prevent the spread of communicable diseases by regulation of water supply and sewage disposal.

B. Migrant housing water well and sewage evaluations are conducted when requested. Records are kept on file in TRAKiT.

- Complaints will be investigated, according to Policy EH-29, Complaints and Enforcement. Corrective actions shall be taken in cases of valid complaints and confirmed outbreaks of illness.

III. GUIDELINES:

A. Every migrant farm operator will request a pre-occupancy inspection as required in GS 95-226(a).

B. Environmental Health shall forward the results of its inspection to the Department of Labor of North Carolina, to the operator, and to the NC Growers Association.

C. Migrant housing water supply is inspected as required under GS 95-225(c). If on a private drinking water well:

1. Wells are inspected to ensure well-head protection and proper ventilation.

2. A water sample is collected for bacteriological analysis.

D. The septic system is inspected as required under GS 95-225(d).

1. The locations of sewage or septic systems are observed **for each proposed migrant worker home**.

2. If a sewage malfunction is observed, it is to be addressed according to Policy EH-7, Guidelines for Malfunctioning Waste Water Systems and Course of Action for Repair.

E. Any solid waste violations are documented by the Environmental Health Specialist and referred to Solid Waste/Code Enforcement.

F. Migrant housing forms (DENR 3765) are completed at the time of inspections. These forms note the number of occupants the septic system is designed to support (2 persons per bedroom) and must indicate if there was or was not visual evidence of water system or septic system non-compliance.

G. The results of the inspection shall be entered into TRAKiT.

H. If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PRIVATE DRINKING WATER WELL INSPECTIONS

DATE DEVELOPED: 6/99
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/19; 6/20; 6/22; 6/23; 6/24

I. POLICY:

Regulation of private drinking water wells based on NC GS 87, Article 7.

II. PURPOSE:

To protect private drinking water wells and water supplies for human consumption **and to protect the public welfare, safety, health and groundwater resources.**

III. GUIDELINES:

A. Well Application and Permitting:

1. Well applications are taken as stated in Policy EH-3, Application Procedures.

2. The Environmental Health Specialist (EHS) issues a permit to construct, abandon, or repair a well as determined by the application. **For new well construction,** the permit shall contain a diagram showing the location of the proposed well and any existing wells, any easements or rights-of-way and distances to adjacent on-site sewage systems, building foundations, surface water bodies, or other potential sources of contamination. A well permit may be denied if setbacks cannot be met on the site or due to other site conditions.

3. When the EHS visits a site and verifies that the proposed location meets the requirements, a tape measure shall be used to measure the distances from structures, property lines, easements, rights-of-way and sewage system(s) (both on the respective lot and adjoining lot if applicable). Property lines, easements, rights-of-way, etc. must be clearly identified on site by the applicant.

4. Once a well permit is issued, it will be attached to the well record in TRAKiT. The information obtained during the permitting process shall be documented in TRAKiT and/or on the well permit.

5. The well is GPS located whenever possible.

B. Casing: Water Supply Wells 15A NCAC 02C .0107(d).

C. Grouting:

1. Grouting inspections shall be completed according to standards of: Grout Inspection and Well Completion 15A NCAC 02C.0305 and 15A NCAC 02C .0107(e)-(f) or approved per Session Law 2022-11.

2. The EHS shall properly and completely document his/her findings in TRAKiT.

D. Final **Well** Inspection:

1. Final **well** inspections are completed according to the requirements of 15A NCAC 02C .0306, 15A NCAC 02C .0307 and 15A NCAC 02C .0107(j).

2. If all of the above requirements are met, a Certificate of Completion is issued.

3. The EHS shall properly and completely document his/her findings in TRAKiT.

E. Water Sample Collection:

1. Water samples will be collected from newly constructed private drinking water as required under 15A NCAC 18A.3802 and 15A NCAC 18A .3803 once power is supplied to the well. The well owner shall contact Environmental Health once power is supplied to the well pump to have the samples collected.

2. The EHS will provide the results of the water samples to the well owner or applicant, including any information concerning chemical and biological contaminants exceeding public drinking water MCLs.

F. If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ANIMAL CONTROL ORDINANCE – DANGEROUS OR VICIOUS, PUBLIC NUISANCE, AND RUNNING AT LARGE ANIMALS

DATE DEVELOPED: **12/05**
REVIEWED: **6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/17; 6/20; 6/24**

I. POLICY:

Rockingham County animal control (including sections prohibiting animals running at large and public nuisances, and providing restrictions for dangerous or vicious animals) shall be conducted in accordance with the Rockingham County Animal Control Ordinance adopted by the Rockingham County Commissioners in July 1998 and amended in January 1999 and August 2016. Enforcement of the Animal Control ordinance is authorized by NC General Statute 153A-123.

II. PURPOSE:

To provide for enforcement of all laws of North Carolina and all ordinances of Rockingham County pertaining to animals and for cooperation with all law enforcement officers within Rockingham County in exercising its authority. The Health Director and Environmental Health Section cooperate with the Animal Control Division of the Rockingham County Sheriff's Department and municipal police departments in Rockingham County – the police agencies enforcing the animal control law and regulations.

III. GUIDELINES:

A. Animals are prohibited from running at large.

- Restraint of an animal is required on property of the animal owner. On a lot or plat of real property one acre or greater, the animal does not have to be kept under physical restraint while on the premises.

B. Animals are prohibited from constituting a public nuisance by:

1. Disturbing the rights of a member of the general public.
2. Threatening the safety of the general public.
3. Damaging a member of the general public.
4. Interfering with the ordinary use and enjoyment of another's property.

C. An order and citation may be issued by an Animal Control Officer when it is determined that an animal constitutes a public nuisance.

- The order states how a public nuisance animal is to be confined to prevent the animal from constituting a public nuisance.

D. Animals determined to be dangerous or vicious by an Animal Control Officer or Law Enforcement Officer, in instances where the animal has not been involved in an incident involving serious bodily injury or death to a person, may be kept by enclosure in a structure described in the ordinance or by being securely muzzled and under restraint.

Any person who owns an animal that has been declared dangerous or vicious by an Animal Control Officer or Law Enforcement Officer shall have the right to appeal this decision to the Rockingham County Health Director.

1. The owner has the right to request a hearing contesting the determination by submitting a written request to the Health Director as described in the ordinance.

2. The Health Director or Designee shall conduct a hearing to decide if a determination of dangerous or vicious is correct or incorrect.

3. If the Health Director or Designee concludes the animal is dangerous or vicious, the Animal Control Division shall dispose of the animal according to the ordinance. This decision is FINAL.

4. If an animal is judged not to be dangerous or vicious, it shall be returned to the owner without charge.

E. Unless proof of current rabies vaccination can be furnished, every person who redeems a dog or cat at a holding facility or animal shelter must obtain and submit the fee for a rabies voucher at the time of redemption.

F. The Animal Control Ordinance provides for compliance with State Rabies Laws – Supplement to State Rabies Laws.

1. Current vaccination against rabies is required for a dog or cat four (4) months of age or older.

2. The Health Director or the Board of County Commissioners may deem it necessary to vaccinate other domestic animals or pets in order to prevent or control a threatened epizootic or epidemic or to control an existing epizootic.

ANIMAL CONTROL ORDINANCE - DANGEROUS OR VICIOUS, PUBLIC NUISANCE, AND RUNNING AT LARGE ANIMALS
POLICY 3

3. The Health Director or Designee (Environmental Health Director) shall coordinate with the Rockingham County Animal Shelter to assist with a rabies vaccination clinic at least annually.

4. Notice is required to be submitted to the Health Director or Designee when a person has been bitten by an animal having rabies or suspected of having rabies, as required by the ordinance.

5. The Health Director or Designee may designate the place to immediately and securely confine an animal having rabies or suspected of having rabies for ten (10) days at the expense of the owner.

6. The Animal Control Ordinance requires reports about persons bitten by any animal known to have or to be a potential carrier of rabies to be made to the Health Director.

7. When a person has possession or control of an animal having rabies or suspected of having rabies, refuses confinement**,** the Health Director may order seizure of the animal and its confinement in such place as the Health Director designates. Such an animal shall not be released from confinement except by permission from the Health Director.

8. Law Enforcement agencies investigating animal bites shall report bites to the Health Director or Designee, as required by the ordinance.

9. When reports indicate a positive diagnosis of rabies to the extent the lives of persons are endangered, the Health Director may declare an area-wide quarantine for a period of time deemed necessary.

10. During an area-wide emergency quarantine, the Health Director or Designee and any Animal Control or Law Enforcement Officer may seize and impound any dog or cat found to be running at large in Rockingham County.

11. During the area-wide emergency quarantine period, the Health Director shall be empowered to provide a program of mass immunization by the establishment of temporary emergency rabies vaccination facilities strategically located throughout the county.

12. In the event there are additional positive cases of rabies occurring during the period of quarantine, such period of quarantine may be extended at the discretion of the Health Director.

13. If an animal dies while under observation for rabies, the head of such animal shall be submitted to the North Carolina Laboratory of Public Health for rabies diagnosis.

14. The head of any animal suspected of dying of rabies which may have exposed a person or domestic pet to infected saliva on brain tissue, shall be **prepared and** surrendered to the Public Health Division and shall be shipped to the North Carolina Laboratory of Public Health for rabies diagnosis in accordance with laboratory policies and procedures.

15. Badly wounded, diseased, or suffering animals which are suspected of having rabies may be humanely destroyed immediately and the head forwarded to the State Laboratory of the North Carolina Department of Health and Human Services for examination.

16. It shall be unlawful for any person to kill or release any animal under observation for rabies or any animal under observation for biting a human, or to remove such animal from the county without written permission from the Health Director. A licensed veterinarian or the Health Director or Designee may authorize any animal to be killed for rabies diagnosis.

17. It shall be unlawful for any person to fail or refuse to surrender any animal for confinement or destruction, as required by the ordinance, when demand is made by the Health Director or Designee.

18. It shall be unlawful for any person to fail or refuse to provide proof of rabies vaccination for any animal that he or she owns or controls when request is made by the Health Director, Designee, or any sworn Law Enforcement Officer.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: FLI (Food, Lodging, and Institutions) PERMITS AND TRANSITIONAL PERMITS

DATE DEVELOPED: 1/07
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18; 6/20; 6/22; 6/24

I. POLICY:

Pursuant to GS 130A – 248 (b), all food, lodging, and camping establishments shall have a valid permit or transitional permit to operate.

II. PURPOSE:

A. To require food service establishment operators to submit the required application, including floor plan and menu, when opening a new food service establishment or when taking ownership of an existing food service establishment.

B. To require lodging and camping establishment operators to submit the required application, including a floor plan, when opening a new establishment or when taking ownership of an existing establishment.

III. GUIDELINES:

A. The application for plan review must be submitted along with a scaled floor plan and menu to the State Plan Review Office or to Environmental Health before a food service establishment can be evaluated to determine if it meets the requirements for a permit or transitional permit

1. Floor plans and applications for new prototype franchised or new chain facilities must be submitted to the State Plan Review Office.

2. Floor plans and applications for all other food service establishments must be submitted to Rockingham County Environmental Health.

B. Permits and transitional permits are not transferable from one owner to another. A permit or transitional permit will be issued only after Environmental Health has reviewed the completed application, evaluated the proposed facility, and determined that it meets all requirements of the applicable rules.

C. Upon discovery that an establishment has changed ownership and is continuing to operate under the previous owner's permit, the operator will

be required to close the establishment until the required application, including floor plan and menu, has been submitted to Environmental Health and a permit or transitional permit has been issued.

D. The Environmental Health Specialist shall complete all applicable forms at the time of permit issuance. The Environmental Health Specialist may use additional forms as needed. The forms used are:

1. Permit to Operate Establishment Form, EHS 1341

2. Comment Addendum Form, EHS 4008

3. Food Service Establishments Inspection Form, EHS 4007

4. Pushcarts and Mobile Food Units Inspection Form, EHS 2902

5. Summer Camps Inspection Form, EHS 1050

6. Resident Camp Inspection Form, EHS 3601

7. Lodging Establishments Inspection Form, EHS 3977

8. Primitive Experience Camps Inspection Form, EHS 4061

E. Permitting for food service establishments shall be done in accordance with 15A NCAC 18A .2659.

1. **The Environmental Health Specialist shall review complete applications and notify the applicant of plan approval**. The application, menu, and floor plan will be reviewed to ensure compliance with all requirements of the "Rules Governing the Sanitation of Food Service Establishments" including:

   a. Size of Water Heater(s)
   b. Equipment Specifications
   c. Materials Used in the Construction of Floors, Walls and Ceilings
   d. Waste Water Disposal
   e. Water Supply

2. Once an application is approved, the Environmental Health Specialist schedules an evaluation of the facility with the applicant for the purpose of issuing a permit.

3. If the food service establishment is compliant with all applicable rules, a permit will be issued using CDP Mobile software on mobile computers.

4. If an establishment is changing ownership, a transitional permit may be issued if the establishment has noncompliant items that are construction or equipment problems which do not represent a threat to public health.

    a. The transitional permit shall expire 180 days after the date of issuance.
    b. All noncompliant items found at the time of permit issuance shall be listed on a Comment Addendum which is signed by the applicant and the Environmental Health Specialist. A copy of this list shall be provided to the applicant.
    c. The applicant must correct all noncompliant items within the 180-day transitional period and obtain a permit, or the food service establishment must close until a permit can be obtained.
    d. Transitional permits are not renewable.

F. Permitting of lodging or camping establishments shall be done in accordance with the establishment's applicable rules.

1. The Environmental Health Specialist shall review complete **applications and notify the applicant of approval**. The application will be reviewed to ensure compliance with all applicable rules including:

    a. Size of Water Heater(s)
    b. Equipment Specifications
    c. Materials Used in the Construction of Floors, Walls and Ceilings
    d. Waste Water Disposal
    e. Water Supply

2. Once an application is approved, the Environmental Health Specialist shall schedule an evaluation of the facility with the applicant for the purpose of issuing a permit.

3. If the establishment is compliant with all applicable rules, a permit will be issued using CDP Mobile software on mobile computers.

3. If an establishment is changing ownership a transitional permit may be issued if the establishment is found to have noncompliant items

that are construction or equipment problems which do not represent a threat to public health.

a. The transitional permit shall expire 180 days after the date of issuance for resident camps.
b. The transitional permit shall expire 180 days after the date of issuance for lodging establishments.
c. A transitional permit cannot be issued to primitive experience camps.
d. All noncompliant items found at the time of permit issuance shall be listed on a Comment Addendum which is signed by the applicant and the Environmental Health Specialist. A copy of this list shall be provided to the applicant.
e. The applicant must correct all noncompliant items within the transitional period and obtain a permit, or the establishment must close until a permit can be obtained.
f. Transitional permits are not renewable.

G. Documentation shall be handled as follows:

1. Forms shall be left with a responsible person at the time of permit issuance.

2. The permit shall be posted in a conspicuous place until the first sanitation inspection is done and a sanitation placard is posted.

- The first sanitation inspection shall be done within 15 to 30 days from the date of permit issuance.

3. A copy of the forms shall be placed in the Environmental Health files and kept in accordance with the Records Retention and Disposition Schedule issued by the N.C. Department of Cultural Resources, including any results from the State Laboratory of Public Health and a copy of a notice or letter indicating sample results.

I. Appeals:

If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TEMPORARY FOOD ESTABLISHMENTS

DATE DEVELOPED: 6/08
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18; 6/22; 6/24

I. POLICY:

A temporary food establishment (TFE) must be permitted in accordance with General Statute §130A-248(a) and (b) and rule 15A NCAC 18A.2665-.2669 located in the Rules Governing The Food Protection and Sanitation of Food Establishments.

II. PURPOSE:

To ensure non-exempt temporary food establishments (TFE) at a transitory fair, carnival, circus, festival, public exhibition, or agritourism business are permitted as required.

III. GUIDELINES:

A. All non-exempt TFE **vendors** must submit a complete Temporary Food Establishment Vendor Application and fee at least 15 calendar days prior to the date of the event. This application must include all information as required in 15A NCAC 18A .2665(d).

B. All exempt applicants must provide documentation that they meet the exemption under General Statue 130A-250(7) prior to the event.

C. Once a completed application has been received, an Environmental Health Specialist will review the application and contact the applicant to set up an appointment to conduct an evaluation for a permit.

D. One or more Environmental Health Specialists (depending on the size of the event) will go to the event site to evaluate non-exempt TFE vendors at least one hour prior to the start of the event, unless an earlier appointment time has been set.

E. If all requirements under 15A NCAC 18A.2665-.2669 have been met, a permit will be issued to the TFE vendor. The permit must be posted in a conspicuous place where it can be readily seen by the public at all times. The Environmental Health Specialist will completely fill out all applicable forms as needed. The forms used are:

1. Permit to Operate Establishment Form, EHS 1341

2. Comment Addendum Form, EHS 4008

F. Information on the permit will include:

1. Name and location of the TFE and TFE Commissary
2. Permit Holder
3. Name and location of the event
4. Dates of operation
5. Any other conditions necessary to remain in compliance with 15A NCAC 18A .2665-.2669

G. Evaluations of the TFE may be made as often as necessary to ensure compliance with all applicable rules and regulations.

H. An Environmental Health Specialist may immediately suspend a TFE permit for a violation related to food protection, water supplies, sewage disposal, or employee hygienic practices.

I. All permits are completed on mobile computers using CDP Mobile software or in the office using CDP Software.

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J. A copy of the permit shall be placed in the Environmental Health files and kept in accordance with the Records Retention and Disposition Schedule issued by the N.C. Department of Cultural Resources, including any results from the State Laboratory of Public Health and a copy of a notice or letter indicating sample results.

K. Appeals:

If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: INSPECTION OF REGULATED FACILITIES CONNECTED TO ON-SITE SANITARY SEWAGE SYSTEMS

DATE DEVELOPED: 10/27/09
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18; 6/23; 6/24

I. POLICY:

To investigate the on-site sanitary sewage system of any regulated facilities during routine sanitation inspections.

II. PURPOSE:

To ensure that on-site sanitary sewage systems of regulated facilities are functioning and operating in accordance with the "Laws and Rules for Sewage Treatment and Disposal Systems" 15A NCAC **18E**.

III. GUIDELINES:

A. During routine compliance inspections, the Environmental Health Specialist (EHS) **will check** the sanitary sewage **disposal** of the facility to ensure that all sewage and liquid waste is being disposed of by an approved, properly operating on-site sanitary sewage system.

B. If the EHS finds that the on-site sanitary sewage system appears to be malfunctioning, an authorized EHS in On-Site Wastewater shall be contacted to investigate the on-site sanitary sewage system malfunction.

C. The EHS may deduct points for the system malfunctioning on the inspection sheet. The EHS must consult with his/her immediate supervisor (or the Environmental Health Director), and have documentation from an EHS authorized in On-Site Wastewater before taking any permit action, issuing any Disapprovals, or setting any time lines for corrections.

D. In keeping with an appropriate chain-of-command, the EHS may only contact the Regional Environmental Health Specialist for that type of establishment after consulting with his/her immediate supervisor (or the Environmental Health Director) for guidance on how to handle the situation.

E. The EHS must consult with an EHS authorized in on-site wastewater regarding time lines for repairs of malfunctioning sanitary sewage systems.

Permit action or Disapproval status can only be issued if the owner or operator is refusing to repair the on-site sanitary sewage system.

F. Appeals:

If a complaint is filed in regard to a state enforcement action by this department, the client will be notified of their right to appeal to the North Carolina Office of Administrative Hearings and/or the appropriate entity according to the NC General Statutes.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MAINTENANCE OF FIELD EQUIPMENT

DATE DEVELOPED: 4/18
REVIEWED: 6/18; 1/19; 6/19; 6/20; 6/21; 6/22; 6/23; 11/23; 6/24
REVISED: 1/19; 11/23; 6/24

I. POLICY:

Equipment used in Environmental Health programs will be maintained as required by the manufacturer's recommendations to ensure proper function.

II. PURPOSE:

To maintain the accuracy of equipment used during inspections and site evaluations.

III. GUIDELINES:

Thermocouples:

Each Thermapen is individually factory-calibrated using very high-precision temperature standards that are traceable to NIST (national standards). A certificate with actual test data is supplied with each Thermapen. Environmental Health Specialists who are conducting inspections will check the accuracy of their thermocouple during each inspection when checking the accuracy of an establishment's thermometer(s) by using the Ice-Point method.

1. Ice-Point Method

    a. Fill a container with ice (crushed is preferable). Add cold, clean tap water until it reaches the top of the ice. Stir the mixture well so that it will be at 32°F.
    b. Put the end of the clean thermometer or probe stem into the ice water so that the sensing area is completely submerged, but the stem does not touch the bottom or sides of the glass. Wait 30 seconds. The thermometer stem or probe stem must remain in the ice water.

2. Thermometers that are not accurate or found to be damaged will be taken out of service.

Laser Levels:

Laser levels are checked by the OSWW Program Coordinator for accuracy by using the manufacturer's instructions. **Laser levels that are found to be inaccurate or damaged will be taken out of service.**

iPhones and iPads:

If an iPhone or iPad is damaged, it shall be reported to the Environmental Health Director immediately. These devices are used for GPS purposes and must be in good operating condition.

Dish Machine Thermometers:

Thermoworks DishTemp thermometers come with a NIST-Traceable certificate of calibration out of the box and does not require regular verification of its accuracy. It is recommended to certify DishTemp annually with accurate temperature standards at 160°F.

Light Meters:

Accuracy of light meters that are in use will be checked against a NIST-Traceable certified light meter that does not require verification of its accuracy. Light meters that are found to be inaccurate or damaged will be taken out of service.

IV. <u>TRAINING</u>:

Environmental Health Specialists working in the FLI Program are trained how to maintain equipment by the Environmental Health Programs Coordinator.

Environmental Health Specialists working in the OSWW Program are trained how to maintain equipment by the OSWW Program Coordinator.

Environmental Health Field Equipment List:

Thermocouples
Infrared Thermometers
Dish Machine Thermometers
Sanitizer Test Strips
Light Meters
Data Logging Thermometers
Pool Chemistry Test Kits
Underwater Cameras
Laser Levels
Chlorine Tablet Test Kits
Clinometers
Augers

Munsell Color Guides
GPS **Antenna**
iPhones
iPads
Ground Penetrating Radar and accompanying tablet

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: QUALITY ASSURANCE PROGRAM

DATE DEVELOPED: 4/13
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/20; 6/22

I. POLICY:

Rockingham County Environmental Health Section will provide quality assurance reviews of work completed by Registered Environmental Health Specialist (REHS) in mandated programs of the Environmental Health Services Program. .

II. PURPOSE:

To ensure that uniform, high quality inspections are conducted in a professional manner at a frequency based on risk assessment. The quality assurance program will be used to identify deficiencies in quality and consistency through proper documentation and to highlight areas for improvement in training, mentoring, and coaching of Environmental Health Specialists. Additionally, the Environmental Health Services Quality Assurance Program shall be implemented to ensure timely and courteous service to our citizens.

III. GUIDELINES:

A. Program Assessment:

The Environmental Health Programs Coordinator is tasked with:

1. Developing, coordinating, and implementing a Quality Assurance Program for the evaluation of the Environmental Health Services Programs (EHSP) and Environmental Health Specialists (EHSs).

2. Verifying that food establishments are assigned to proper risk categories.

3. Using the Quality Assurance Program to identify training needs and opportunities, promote uniformity and proficiency of field inspections, and encourage high quality customer service.

4. Conducting joint inspections with EHSs. The Environmental Health Programs Coordinator shall conduct joint inspections with all EHS working in the EHSP. A joint inspection includes completion of an evaluation form. Frequency of joint inspections will be no less than one (1) per year per EHS working in the EHSP.

5. The Regional Environmental Health Specialist (REHS) shall accompany and observe the Environmental Health Programs Coordinator on at least one inspection annually.

6. An audit shall be made independently by the Environmental Health Programs Coordinator within a reasonable timeframe following the EHS's completion of routine inspections or re-inspections. A minimum of 10% of all completed inspections will be audited. An audit includes completion of an evaluation form, review of the inspection report compared to the previous inspection report including any critical violation visits and recent complaint investigations. Audits will assure that EHSs:

   a) Determine and document the compliance status of each risk factor and intervention through observations and investigation;
   b) Complete an inspection report that is clear, legible and accurately records findings, observations and discussion with management;
   c) Review past inspections and act on all repeated/ unresolved violations;
   d) Follow through with compliance and enforcement;
   e) Obtain and document on-site corrective action for risk factor violations at time of inspection;
   f) Document options for the long-term control of risk factors when repeated risk factor violations are found;
   g) File reports and other documents in a timely manner.

7. Tracking inspection frequency with regard to prescribed inspection dates (i.e., due lists) and timeliness of submission of reports.

8. Reviewing the Quality Assurance Program evaluation documents with EHSs, providing feedback and corrective actions as necessary.

9. Accessing the Quality Assurance Program annually to determine the overall effectiveness of the program and to identify any quality or consistency problems within the program.

B. Corrective Action for Deficiencies:

Additional training, mentoring, and coaching will be provided when areas for improvement in quality, knowledge, skills or abilities in any aspect of the program are identified.

C. Staff Meetings:

1. Staff Meetings will be held monthly.

2. Meetings will be used to review rules, discuss any questions employees have regarding field or office work, review Environmental Health Policies and encourage suggestions for improvement from all staff.

D. Satisfaction Surveys:

Surveys are on the EHSs' signature line which allows clients or regulated facilities to assess services after they have been provided.

E. Complaints:

1. All Environmental Health Complaints are recorded and assigned to an REHS to investigate.

2. The REHS takes detailed notes during the investigation recording only the facts, such as names of individuals involved, dates of importance, findings, results**,** etc.

3. The REHS determines during the investigation the validity of the complaint.

4. Appropriate action is taken for valid complaints (education, notice of violation, intent to suspend, etc.)

F. Forms and Records:

1. Forms used in Quality Assurance Reviews shall be kept electronically on the Rockingham County Division of Public Health server under RCDPH Policies – Environmental Health.

2. Forms shall be updated on the server when changes are made.

3. Server space as of 4/18/16 is called T:drive.

4. Records documenting the results of reviews shall be retained in accordance with DHHS Records Retention and Disposition Schedule.

Rev/di

QA Food Establishment Inspection Report Review

Establishment Name:	
Establishment ID:	
Date Inspected:	
Inspection Completed By:	
Score:	
Previous Score:	

Items Evaluated	Y	N	Comments
Was all of the Demographic Information filled out?			
Was the Time In and Time Out recorded?			
Was the Compliance Status filled out for all 54 items?			
Were the temperature observations recorded correctly with location and temperature?			
Was the correct Compliance status filled out?			
Was the correct Establishment Type selected?			
Were all Priority and Priority Foundation violations CDI or marked for VR?			
Were the correct points taken for repeat violations of Priority and Priority Foundation Items?			
Were the correct points taken for Priority and Priority Foundation Violations if they were not CDI?			
Was Food Manager Certification information recorded for PIC if marked “In Compliance”?			
Were the correct citations cited for each violation on the Comment Addendum?			

Corrections Needed

EH-37 QA worksheet 2016.xlsx

(Double click on icon to view QA Worksheet)

SHEET-MARKING INSTRUCTIONS

Uniform Retail Food Program Inspections

REHS Field Assessment

STATUS OF OBSERVATIONS:

IN Item found in compliance (**IN** Compliance marking must be based on the description under each item number). This refers to the performance of the REHS during the inspection, and is not related to the compliance status of the facility found during the inspection.

OUT Item found out of compliance (**OUT** of Compliance marking must be based on the description under each item number). This refers to the performance of the REHS during the inspection, and is not related to the compliance status of the facility found during the inspection.

NA Not applicable (**NA** marking is made when the data item is NOT part of the REHS's assessment of the food service establishment.)

REHS: Registered Environmental Health Specialist (intern)

Prior to Inspection

Reviews (1-3) previous inspections

IN This item is marked **IN** if the REHS does necessary review of previous inspections to identify areas of repeat violations, whether consumer advisory, variance, HACCP and/or highly susceptible population are present.

OUT This item shall be marked **OUT** if the REHS fails to review previous inspections prior to the inspection.

NA This item is marked **NA** if the REHS is doing an inspection on a newly permitted establishment that does not have previous inspections to review.

Reviews permit conditions, TPHC, variance/HACCP

IN This item is marked **IN** if the REHS reviews, prior to inspection, the included file documents. The REHS must review the permit and permit conditions, menu if attached, and any supporting documentation, including time as a public health control, variance and/or HACCP plans, non-continuous cooking processes. The REHS must also review onsite waste water and water supply documentation from file, if applicable. All applicable file documents must be included in order to mark this **IN**.

OUT This item shall be marked **OUT** if the REHS does not review file documentation, or does not do a full review of all file documents.

NA Marking this is not an option for this item. If the REHS attempts to review file paperwork, regardless of what is available, this item should be marked **IN**.

REHS properly equipped

IN This item is marked **IN** if the REHS has all equipment needed to conduct a risk based inspection. In order to be marked IN compliance, the REHS must have: calibrated thin probe thermometer, chemical test strips, holding thermometer or temperature indicating strips, and flash light. The REHS must also have either alcohol swabs, OR use facility sanitizer to properly sanitize thermometer during inspection, as well as have access to a light meter when needed. REHS must also be equipped with necessary inspection forms (or working field client),

comment addendum, suspension/revocation forms, embargo/product disposition forms, and grade cards.

OUT This item shall be marked **OUT** if the REHS is missing any of the above necessary equipment and paperwork needed for conducting an inspection. Any (1) missing piece of equipment or form will result in this item being marked **OUT**.

NA Marking this is not an option for this item.

Conducting the Inspection

Properly identifies himself/herself

IN This item is marked **IN** if the REHS identifies himself or herself upon entering the facility. In order to be **IN**, the REHS must state name, name of department, and purpose of the visit clearly BEFORE entering the kitchen or other non-public areas of facility. The REHS must ask permission and gain consent from some food service employee before entry. There may be varying levels of formality of this, but as long as there is acknowledgement of consent, this item should be marked IN.

OUT This item shall be marked **OUT** if the REHS fails to identify themselves by name, organization, or purpose. This item shall also be marked **OUT** if the REHS enters kitchen before identification and acknowledged consent or if the REHS does not speak clearly during identification.

NA Marking this is not an option for this item.

Menu Review

IN This item is marked **IN** if the REHS does an adequate review of the menu, preferably at the beginning of the inspection. The REHS must check menu for any new products or procedures, identify any items that may be served undercooked, be prepared using specialized process, or may be cooked/cooled, affecting risk category. The REHS must also inquire about any process changes either during the menu review or the inspection.

OUT This item shall be marked **OUT** if REHS does not attempt a review of the menu at any point during the inspection, OR if during the menu review, the REHS misses a major component of menu review, such as new products or procedures, identify any items that may be served undercooked, be prepared using specialized process, or may be cooked/cooled, affecting risk category. This item shall also be marked **OUT** if there is no inquiry about any process changes at any point during the menu review or the inspection.

NA Marking this is not an option for this item.

Ask PIC to accompany during inspection

IN This item is marked **IN** if the REHS asks the person in charge (PIC) to accompany them during the inspection.

OUT This item is marked **OUT** if the REHS fails to ask the PIC to accompany them during the inspection. This item should **NOT** be marked **OUT** if the REHS asks the PIC to accompany and the PIC declines, or if there is no PIC on site at the time of inspection.

NA Marking this is not an option for this item.

Verifies ownership, demographics

IN This item is marked **IN** if the REHS verifies the ownership and other demographic information with the PIC or the owner during the inspection.

OUT This item is marked **OUT** if the REHS does not verify the ownership and demographic information is correct, or if the REHS fails to update demographic information.

NA This item would be marked **NA** if the facility is known to be owned by a government entity (catered elderly nutrition site, public school lunchrooms, etc.)

Surveys facility; prioritizing risk factors

IN This item is marked **IN** if the REHS does a survey of the kitchen and food preparation areas and determines which risk factors should be first assessed. The REHS should identify any active preparation, and should give priority to: bare hand contact/handwashing violations, cooking temperatures, reheating, and cooling items.

OUT This item is marked **OUT** if the REHS does not first do a survey of the facility and begins a portion of the inspection (such as taking temperatures on a static cold holding line or testing sanitizer strength) without first identifying all risk factors. This item shall also be marked OUT if the REHS improperly prioritizes the inspection after doing the survey, and puts static processes (chemical sanitizer, dish areas when there is no active processing, walk-in coolers, dumpster, GRP cleanliness issues) first before assessing the active food preparation and employee issues.

NA Marking this is not an option for this item.

Appropriate Attire/Complies with facilities policies

IN This item is marked **IN** if the REHS is dressed in a professional manner, meeting all applicable county dress codes (including slip resistant shoes). In lieu of a county dress code policy, REHS must meet the requirements of a food handling employee in the Food Code (hair restraint, no hand or wrist jewelry except plain band, no fake or painted fingernails.) This item is marked **IN** if the REHS is respectful and compliant with any additional policies and procedures required of the facility. This could include wearing a lab coat, removing additional jewelry, covering visible tattoos, or any other facility required policy.

OUT This item is marked **OUT** if the REHS fails to comply with county dress code AND/OR Food Code policy for food handling employees. This item is marked **OUT** if the REHS fails to be compliant with any additional policy that is provided by the facility. If any piece of attire required by dress code or Food Code is missing, this item must be marked **OUT**.

NA Marking this is not an option for this item.

Professional Rapport

IN This item is marked **IN** if the REHS is able to maintain a professional demeanor throughout the inspection, and is able to communicate effectively and professionally with PIC and other employees. REHS should provide positive feedback, communicate in clear and effective language, refrain from raising voice and provide solutions to violations that are reasonable for facility.

OUT This item is marked **OUT** if the REHS fails remain professional throughout the inspection. Examples of behaviors that would result in this item being marked OUT include: using unprofessional language, speaking unprofessionally to PIC or other staff, yelling or raising voice, derogatory remarks, cultural insensitivity towards food being served, customers, or employees, etc.

NA Marking this is not an option for this item.

Risk Factors/Processes

Verifies Certified Food Manager, PIC Duties (Grade Sheet #1)

IN This item is marked **IN** if the REHS properly verifies that the PIC has passed an ANSI accredited exam as required by the rules, AND verifies that all portions of manager duties are being followed. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS fails to ask to see the ANSI accreditation, accepts a certificate of someone who is not on site, or fails to assess active managerial control during the inspection.

NA Marking this is not an option for this item.

Employee Health (Grade Sheet #2,3)

IN This item is marked **IN** if the REHS is able to properly assess the employee health policy that is in the facility. REHS must ask questions of the policy, check for written verification of policy, and verify that proper exclusion and restriction are in place at the time of inspection (no visible infected cuts, and no employees with vomiting, diarrhea present at time of inspection). Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS fails to ask about the employee health policy, counts the facility **IN** compliance with an incomplete or incorrect employee health policy, or incorrectly assesses exclusion and restriction. If REHS misses any (1) of these, this item should be marked **OUT**.

NA Marking this is not an option for this item.

Good Hygienic Practices (Grade Sheet #4,5)

IN This item is marked **IN** if the REHS is able to recognize employees that are eating or drinking in unapproved areas of the kitchen, and ensure no employees are seen during inspection with active eye, nose, and/or mouth discharge. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS misses the opportunity to evaluate eating or drinking, or if the REHS does not assess or incorrectly assesses eye, nose and mouth discharge. If REHS misses any (1) of these, this item should be marked **OUT**.

NA Marking this is not an option for this item.

Handwashing (Grade Sheet #6, 8)

IN This item is marked **IN** if the REHS spends adequate time evaluating handwashing in the facility. The REHS must be able to actively watch employees during preparation and cleaning activities, determine when handwashing would be required by the rules, and adequately instruct and correct employees when improper handwashing is done. All handsinks in the facility must be evaluated for proper use, soap, and paper towels. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address handwashing of employees during the inspection, does not redirect and coach employees that are seen practicing improper handwashing, provides incorrect information to employees about handwashing during inspection, or misses improperly used/stocked handsinks in the facility during the inspection. If REHS misses any (1) of these, this item should be marked **OUT**.

NA Marking this is not an option for this item.

No Bare Hand Contact (Grade Sheet #7)

IN This item is marked **IN** if the REHS accurately interprets and applies the rules that apply to bare hand contact with foods. REHS must not allow bare hand contact with any ready to eat foods, unless it is immediately prior to cooking to 165F, provide correct information about when bare hand contact is allowed, and must determine an appropriate corrective action for any violations of this rule seen to be out of compliance. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address bare hand contact with RTE foods, does not verify foods, such as pizza toppings handled with bare hands reach 165F, or provides incorrect corrective action after bare hand contact violations. If REHS misses any (1) of these, this item should be marked **OUT**.

NA Marking this is not an option for this item.

Approved Sources (Grade Sheet #9, 10, 11, 12, 15, 30)

IN This item is marked **IN** if the REHS appropriately evaluates sources of food during the inspection. The REHS is expected to be aware of requirements of all food sources and take appropriate measures to assess whether source or food product is approved. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not ask or verify any information on food sources.

NA Marking this is not an option for this item.

Food Storage and Protection (Grade Sheet #13, 37, 12, 31)

IN This item is marked **IN** if the REHS does an adequate assessment of cross contamination and food protection during the inspection. The REHS must adequately address any issues of single use gloves being used for multiple tasks, reuse of single use gloves, and instruct facility on proper corrective action if violations are seen. REHS must also be able to properly assess food storage within cooler to ensure there is no cross contamination, segregation of equipment to prevent cross contamination, and food contact with surfaces other than cleaned, sanitized utensils or approved single service. Any customer self-service areas must be properly evaluated for adequate protection, and any other food storage issues must be addressed during the inspection. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address cross contamination or food protection during the inspection, does not properly instruct on use of single service gloves and cross contamination potential, incorrectly evaluates food protection issues, or misses providing feedback on contamination potential in customer self-service areas. If REHS misses any (1) of these, this item should be marked **OUT**.

NA Marking this is not an option for this item.

Cleaning & Sanitizing Food Contact Surfaces (Grade Sheet #14)

IN This item is marked **IN** if the REHS is able to adequately evaluate the cleaning and sanitizing of utensils and food contact surfaces in the facility. This item should be marked **IN** when the REHS spends appropriate time on evaluating procedures for cleaning, checks all sanitizer and dish machines where applicable, and uses appropriate procedure for verifying proper operation of dish machines. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not evaluate cleaning and sanitizing practices in the facility, misses the opportunity to check operation of dish machine, or does not verify sanitizer concentration at any point during inspection. If REHS misses any (1) of these, this item should be marked **OUT**.

NA Marking this is not an option for this item.

Cooking (Grade Sheet #16)

IN This item is marked **IN** if the REHS spends appropriate time evaluating cook temperatures during the inspection, including the assessment of the facility that may have uncooked or cooked to order food. Since this is one of the most dynamic processes that occur during an inspection, the REHS must be able to multi-task and continuously return to the cook line for temperatures as they continue with other risk factors, if cooking is occurring. In order to be marked **IN**, the REHS is expected to measure a representative sample of any foods that are in the process of cooking, and also be able to communicate with employees on their ability to asses final cook temperatures as well. If the REHS has asked for cooked foods to be held before service to take a cook temperature and the food employee does not wait until cook temperature is documented, the REHS should not be penalized. The REHS must communicate correct final cook temperatures to the employees and PIC and must follow through with providing information on proper corrective actions if violations are seen. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not adequately evaluate cook temperatures during the inspection, provides incorrect information to employees and PIC regarding final cook temperature, or does not provide the information on corrective action when violations are observed. This would also be **OUT** if the REHS refers to a reheating temperature as a cook temperature, or assess a cooked to order food for a final cook temperature and does not recognize the difference.

NA This item is marked **NA** when, during menu review, it is determined that no true cooking is occurring in the facility, OR, at the end of the inspection, there has been no cooking in the facility in order for the REHS to evaluate final cook temperatures.

Reheating (Grade Sheet #17)

IN This item is marked **IN** if the REHS is able to assess the reheating of foods that is occurring during an inspection. The REHS must demonstrate knowledge of the difference between cooking and reheating, and consider all commercially packaged, pre-cooked food a reheat instead of cook temperature. The REHS must properly identify foods that are reheated for hot holding, reheated for immediate service, and foods that are reheated from previous preparation in the facility. The REHS must also identify and communicate proper corrective actions if violations are seen. Even if the facility is out of compliance, this item shall be marked IN on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not evaluate reheating temperatures during the inspection, incorrectly identifies the reheat temperature for a food based on the procedure, or provides incorrect corrective action when violations are observed.

NA This item is marked NA when, during menu review, it is determined that no reheating is occurring in the facility, OR, at the end of the inspection, there has been no reheating in the facility in order for the REHS to evaluate reheat temperatures.

Cooling Parameters (Grade Sheet #18)

IN This item is marked **IN** if the REHS properly assesses the cooling time and temperature parameters that lead to a temperature violation for cooling. The REHS must determine early in the inspection that cooling is already taking place, so that if possible two temperatures of the food can be measured. The REHS must also be able to determine when the time/temperature parameters of cooling have not been met and to communicate appropriate corrective actions with the PIC. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not evaluate cooling during the inspection, misses the opportunity to fully assess cooling by taking temperatures of the product, incorrectly interprets time/temperature parameters of cooling, or provides incorrect information on corrective actions for cooling. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item is marked **NA** when, during menu review, it is determined that no cooling is occurring in the facility, OR, at the end of the inspection, there has been no cooling in the facility in order for the REHS to evaluate cooling temperatures.

Hot Holding (Grade Sheet #19)

IN This item is marked **IN** if the REHS properly assesses hot holding temperatures in the facility. The REHS must demonstrate proper technique in assessing hot holding temperatures and must take temperatures of appropriate representative sample of hot held foods during the inspection, accurately identify items that are out of compliance, and communicate appropriate corrective actions with the PIC. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not demonstrate proper technique, evaluate hot holding during the inspection, or provides incorrect information on corrective actions for hot holding. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item is marked **NA** when, during menu review, it is determined that no hot holding is occurring in the facility, OR, at the end of the inspection, there has been no hot holding in the facility in order for the REHS to evaluate hot holding temperatures.

Cold Holding (Grade Sheet #20)

IN This item is marked **IN** if the REHS properly assesses cold holding temperatures in the facility. The REHS must demonstrate proper technique in assessing cold holding temperatures and must take temperatures of an appropriate representative sample of cold foods during the inspection, accurately identify items that are out of compliance, and communicate appropriate corrective actions with the PIC. Even if the facility is out of compliance, this item shall be marked IN on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not demonstrate proper technique, evaluate cold holding during the inspection, or provides incorrect information on

corrective actions for cold holding. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item is marked **NA** when, during menu review, it is determined that no cold holding is occurring in the facility.

Date Marking (Grade Sheet #21)

IN This item is marked **IN** if the REHS properly assesses the date marking system used in the facility. In order to be in compliance, the REHS must be able to accurately identify foods that require date marking, length of date marking allowed based on holding temperature of product, and be able to communicate appropriate corrective actions with the PIC. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not evaluate date marking during the inspection, incorrectly communicates length of date marking allowed based on the temperature of the product, fails to properly identify items that have been exempted from date marking, or provides incorrect information on corrective actions for date marking. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item is marked **NA** when, during menu review, it is determined that there are no items within the facility that require date marking.

TPHC (Grade Sheet #22)

IN This item is marked **IN** if the REHS properly identifies foods that are being held using time as a public health control. The REHS must ask appropriate questions to determine if foods that are held for specific times meet the requirement for TPHC. The REHS must understand that written procedures do not need to be approved prior to inspection and be able to do a field review of this paperwork if necessary. The REHS must also be able to communicate proper corrective actions if violations are observed. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not evaluate or ask questions about TPHC during the inspection, incorrectly evaluates TPHC procedures if provided during the inspection, or provides incorrect information on corrective actions for TPHC. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item is marked **NA** when, during menu review and discussion with PIC, it is determined that there are no items within the facility that are held using TPHC.

Consumer Advisory/Pasteurized Foods (Grade Sheet #23, 28)

IN This item is marked **IN** if the REHS properly identifies foods that are being served raw or undercooked. The REHS is expected to ask open ended questions in order to make sure facility understands when a consumer advisory is required. The REHS must also be able to assess current consumer advisories that are present to ensure they are complete and provide adequate disclosure and reminder. When menus do not include consumer advisories for items that are undercooked, the REHS must be able to validate the presence of pasteurized foods and ensure that all requirements are met to serve these foods without a consumer advisory. The REHS must also be able to communicate proper corrective actions if violations are observed. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not evaluate or ask questions about consumer advisory during the inspection, incorrectly evaluates consumer advisory if provided during the inspection, does not evaluate the use of

pasteurize products in lieu of a consumer advisory, or provides incorrect information on corrective actions for consumer advisory. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item should not be marked **NA**. If REHS asks appropriate questions and accurately determines that no consumer advisory is needed, the REHS should be marked **IN**.

Chemicals (Grade Sheet #25, 26)

IN This item is marked **IN** if the REHS properly identifies and/or addresses any food additives used in the facility, as well as assesses chemical use and storage during the inspection. The REHS must properly enforce rules regarding chemical bottle labels, storage to prevent cross contamination, and appropriately discuss sanitizer that is over concentration allowed by the CFR. The REHS must also be able to communicate proper corrective actions if violations are observed. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address food additives during the inspection, does not address chemicals storage or excessive sanitizer strength, or provides incorrect information on corrective actions for chemicals. If REHS misses any (1) of these, this item should be marked **OUT**.

NA Marking this is not an option for this item.

Recognizes HSP requirements (Grade Sheet #24)

IN This item is marked **IN** if the REHS properly identifies a highly susceptible population and properly applies the definition. The REHS must ask questions about types of food being served and be able to properly identify if non-pasteurized eggs or juices are being served. The REHS must also be able to communicate proper corrective actions if violations are observed. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not properly identify the highly susceptible population, does not correctly identify non-pasteurized foods being served in the facility, or provides incorrect corrective actions for any of these items. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item is marked **NA** when, during menu and facility review, it is determined this facility does not meet the definition of serving a highly susceptible population.

Specialized Processes

Recognizes Variance/HACCP (Grade Sheet #30)

IN This item is marked **IN** if the REHS properly assesses whether specialized processes are occurring in the facility. The REHS is expected to ask open ended questions and be able to identify equipment that is indicative of a specialized process (vacuum sealer, emersion circulator, pH meters, starter cultures, pink salt). The REHS must also be able to properly communicate when a HACCP plan without variance is needed and when a variance is required, and communicate proper corrective actions if violations are observed. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not properly identify specialized processes, provides incorrect information about when a variance is required, or provides incorrect corrective actions for any of these items. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item should not be marked **NA**. If REHS asks appropriate questions and accurately determines that no specialized processes are taking place, the REHS should be marked **IN**.

Verifies HACCP Plan (Grade Sheet #27)

IN This item is marked **IN** if the REHS properly verifies HACCP plans that are being used in the facility. The REHS is expected to check logs being kept as part of the HACCP plan, verify any CCPs that are being carried out during the inspection, and communicate proper corrective actions if violations are observed. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address HACCP plans during the inspection, misses the opportunity to assess CCPs occurring during the inspection, does not verify logs, or provides incorrect information on corrective actions for any of these items. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item is marked **NA** when, during menu and facility review, it is determined there is no HACCP plan implemented in this facility.

Food Temperature Control

Cooling Methods (Grade Sheet #31)

IN This item is marked **IN** if the REHS completes a proper assessment of cooling practices and procedures during the inspection. The REHS must identify foods that are cooked and cooled, as well as foods that are cooled from room temperature, and foods that are required to be cooled following preparation. The REHS must correctly evaluate methods that are being used in the facility, determine if they are adequate, and communicate proper corrective actions if violations are observed. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address cooling procedures during the inspection, incorrectly identifies foods in as not in cooling process, or provides incorrect information regarding approved cooling methods or corrective actions for any of these items. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item should not be marked **NA**. If REHS asks appropriate questions and accurately determines that no cooling is taking place, the REHS should be marked **IN**.

Recognizes plant food cooking (Grade Sheet #32)

IN This item is marked **IN** if the REHS properly identifies and assesses plant foods that are being cooked in the facility. The REHS must be able to recognize items like rice and beans as plant food and properly assess the cooking, as well as communicate proper corrective actions if violations are observed. Even if the facility is out of compliance, this item shall be marked IN on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address plant food cooking procedures during the inspection, incorrectly identifies foods that are cooked plant food, or provides incorrect information regarding corrective actions for any of these items. If REHS misses any (1) of these, this item should be marked **OUT**.

NA This item is marked **NA** when, during menu and facility review, it is determined there is plant food cooking occurring in the facility, OR, at the end of the inspection, there has been no plant food cooking in the facility in order for the REHS to evaluate.

Thawing Methods (Grade Sheet #33)

IN This item is marked **IN** if the REHS properly evaluates methods of thawing used during the inspection. The REHS must provide clear information on approved thawing methods, and communicate corrected procedures if violations are noted. Adequate discussion of thawing practices when there is not active thawing occurring should result in the REHS being marked **IN**. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address thawing during inspection, does not recognize thawing that is occurring during the inspection, or provides incorrect information on approved thawing procedures.

NA This item is marked **NA** when, during menu and facility review, it is determined there is no thawing occurring in the facility.

Thermometers available and accurate (Grade Sheet #34)

IN This item is marked **IN** if the REHS evaluates the thermometers in use in facility at the time of inspection. REHS is expected to check air temperature thermometers on cold and hot holding units, as well as assess the accuracy and probe diameter of food temperature thermometer provided at time of inspection. The REHS must determine when a thin probe thermometer is required by the rules, properly apply this interpretation, and communicate proper corrective actions if violations are observed. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not check for food temperature thermometer, misses more than 75% of air temperature thermometers that are required, does not appropriately apply the rule requiring thin probe thermometers, or provides incorrect information on corrective actions for these items.

NA Marking this is not an option for this item.

Good Retail Practices

Water and Ice From Approved Sources (Grade Sheet #29)

IN This item is marked **IN** if the REHS adequately assesses the water supply that is used in the facility. The REHS is expected to verify whether the water supply is a community or non-community system. If applicable, the REHS must verify sampling requirements have been met on wells being used in the facility. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not verify the water supply, or incorrectly identifies the water supply and/or sampling requirements.

NA Marking this is not an option for this item.

Food Identification (Grade Sheet #35)

IN This item is marked **IN** if the REHS identifies foods that are required to be labeled and verifies labels are correct. The REHS is expected to check for any

customer self-service packaged foods, “grab and go”, follow state guidance on when ingredient and allergen information is required, understand which items require immediate correction or follow-up (items that are P, Pf) and provide accurate information on corrective actions for these items if found to be out of compliance. The REHS must also verify that any shellstock are being stored in original container, and that all foods can be identified while in storage. Even if the facility is out of compliance, this item shall be marked IN on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address packaged food labeling during inspection, provides incorrect information about when ingredients and allergen information is required, does not check for original container when shellstock are present or provides incorrect information on corrective actions for these items.

NA Marking this is not an option for this item.

Prevention of Contamination (Grade Sheet #36, 38, 39, 40)

IN This item is marked **IN** if the REHS properly assesses the good retail practices that can lead to food contamination. The REHS is expected to address pest control and insects within facility, personal cleanliness of employees, wiping cloth storage, and proper washing of fruits and vegetables. Even if the facility is out of compliance, this item shall be marked IN on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address any of the good retail practices that can lead to food contamination, provides incorrect information about employee cleanliness, wiping cloth storage or fruit/vegetable washing, or if there are pests present that are not addressed by the REHS.

NA Marking this is not an option for this item.

Proper Use of Utensils (Grade Sheet #41, 42, 43, 44)

IN This item is marked **IN** if the REHS properly addresses utensil use during the inspection as it relates to food contamination. The REHS must evaluate whether the facility is in compliance in regards to: in use utensils are properly stored according to the rules, air drying, single service storage, and single use gloves. Even if the facility is out of compliance, this item shall be marked IN on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address any proper utensil use during the inspection, or fails to correct violations in utensil use during the inspection as captured in #41-44 on the inspection sheet.

NA Marking this is not an option for this item.

Utensils and Equipment (Grade Sheet #45, 46, 47)

IN This item is marked **IN** if the REHS properly addresses repair and operation of utensils and equipment as captured in #45-47 of the inspection sheet. The REHS must evaluate whether equipment meets certification requirements, identify which equipment is not required to be ANSI approved, determine when food contact surface repair requires immediate correction or follow-up, verify test strips are present in the facility, and address cleanliness of non-food contact surfaces. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address any repair and operation of utensils and equipment, fails to provide proper corrective actions for test strips

or food contact surface repair, or gives incorrect information about certification requirements for equipment.

NA Marking this is not an option for this item.

Physical Facilities (Grade Sheet #48, 49, 50, 51, 52, 53, 54)

IN This item is marked **IN** if the REHS properly addresses the physical facilities during an inspection. The REHS must verify that there is adequate hot and cold water, backflow prevention devices, waste disposal facilities, toilet facilities and storage facilities for personal belongings. The REHS is also expected to document any deficiencies in lighting, floor/wall/ceiling repair and ability to be cleaned, and cleanliness of the physical facilities. Even if the facility is out of compliance, this item shall be marked **IN** on the field assessment if the REHS has properly assessed this item.

OUT This item is marked **OUT** if the REHS does not address any of the physical facility deficiencies, or provides incorrect information about requirements of waste disposal, backflow, toilet or storage facilities for employee belongings.

NA Marking this is not an option for this item.

Setting Example

EHS washes hands as needed

IN This item is marked **IN** if the REHS does adequate job of washing hands during the inspection, following the requirements of when to wash and how to wash as specified in the food code.

OUT This item is marked **OUT** if the REHS does not wash hands upon entering kitchen, after touching face, upon returning from outside facility, or at any other point where handwashing would be required of a food service employee. This item would also be marked **OUT** if the REHS does not follow handwashing procedure outlined in the Food Code, washed for too short of a time, does not use soap, does not turn water off with paper towel or other methods to avoid hand contamination. If REHS misses any (1) of these, this item should be marked **OUT**.

NA Marking this is not an option for this item.

Properly Uses Equipment

IN This item is marked **IN** if the REHS properly uses equipment required to complete an inspection. The REHS must clean thermometer properly before using and between food species, uses chemical test strips according to instructions, properly verifies operation of hot water sanitizing dish washer by use of holding thermometer or temperature indicating strips, and uses flash light and light meter when appropriate.

OUT This item is marked **OUT** if the REHS does not use equipment when necessary, does not use holding thermometer or temperature indicating strip to verify operation of a hot water sanitizing dish machine, or does not properly clean thermometer during use. If REHS misses any (1) of these, this item should be marked **OUT**.

NA Marking this is not an option for this item.

Paperwork

Proper Code Citation and Item Number Marked

IN This item is marked **IN** if based on the violations that are observed during the inspection, the REHS documents the code section that is violated on the inspection form, and uses marking instructions to correctly identify corresponding item on the grade sheet.

OUT This item is marked **OUT** if the REHS does not mark code citations on the inspection form, incorrectly identifies the item numbers where violations should be marked, or incorrectly identifies the corresponding code citation.

NA Marking this is not an option for this item.

Item properly marked as a repeat violation

IN This item is marked **IN** if the REHS uses previous inspections to verify that the violation is a repeat from previous, clearly communicates the implications of repeat violations to the PIC, and properly documents this on the inspection sheet by marking the “R” column on the form.

OUT This item is marked **OUT** if the REHS does not document repeat violations by marking the correct column on the grade sheet, incorrectly identifies an item as a repeat violation, or fails to communicate with a PIC that a violation is a repeat from a previous inspection.

NA This item is marked **NA** when, after reviewing previous inspections, there are no repeat violations from the previous inspection.

Corrective Action Achieved, CDI noted

IN This item is marked **IN** if the REHS recognizes, based on whether the violation is a priority or priority foundation item, when corrective action is needed. The REHS must recognize what qualifies as true correction during inspection, provide clear language explaining how correction was achieved, and includes the acronym “CDI” on inspection sheet under proper violation number, as well as mark the column for “CDI” on the grade sheet.

OUT This item is marked **OUT** if the REHS does not appropriately document “CDI” on the grade sheet, accepts an inadequate corrective action, or incorrectly determines whether an item is required to have verification of correction.

NA This item is marked **NA** when, after completing the inspection, there are no violations which require verification of correction through CDI.

Verification required properly documented

IN This item is marked **IN** if the REHS recognizes when corrective action has not been achieved during the inspection, and also recognizes that corrective action is required based on the severity of the violation (P or Pf). The REHS must clearly communicate the expectations of correction with the PIC, both verbally and on the inspection sheet, document in correct column on the grade sheet that verification is required “VR”, and provide a follow-up date that is within 10 days of the inspection.

OUT This item is marked **OUT** if the REHS does not properly document on inspection form when verification is required, incorrectly determines that a verification is needed (either the facility achieved on site correction and the REHS does not recognize or the REHS requires a verification on a core item), or does not clearly communicate expectations with PIC.

NA This item is marked **NA** when, after completing the inspection, there are no violations which require verification of correction with a return visit or VR.

Enforcement Action properly taken

IN This item is marked **IN** if the REHS recognizes a pattern of non-compliance on a risk factor violation within a facility. The REHS must use inspection history to determine which enforcement action is most appropriate. The REHS must choose whether it is appropriate to require a risk control plan (RCP), or issue an intent to suspend or immediate suspension. The REHS must provide proper and clear documentation of enforcement action and must clearly communicate with PIC what is being required and the consequences if compliance is not achieved.

OUT This item is marked **OUT** if the REHS does not properly document use of an enforcement action (RCP, intent to suspend or immediate suspension), incorrectly chooses an enforcement action based on the severity of the issue, or fails to take enforcement action when appropriate.

NA This item is marked **NA** when, after completing the inspection, there are no violations which require enforcement action.

Inspection Competencies

I. Proper and consistent use of the inspection form using IN, OUT, NA, NO appropriately. REHS documents the compliance status of each foodborne illness risk factor and intervention through observation and investigation.

IN This item is marked **IN** if the REHS properly marks the inspection form in accordance with the NC inspection report marking instructions. All items are correctly marked in accordance with observations and processes occurring at the time of inspection. REHS has documented temperatures for every Risk Factor process which has been marked either **IN** or **OUT** of compliance on the inspection report.

OUT This item shall be marked **OUT** if the REHS fails to properly mark the inspection report in accordance with the marking instructions. This item shall be marked **OUT** if the REHS fails to properly record temperatures processes occurring at the time of inspection to validate **IN** or **OUT** of compliance on the inspection report.

NA Marking this is not an option for this item.

II. REHS completes an inspection report that is clear, legible, concise, and accurately records findings, observations, accurate score and discussion with establishment management.

IN This item is marked **IN** if the REHS is using a computer in the field, typing or writes clear and legibly. This item is marked **IN** if the REHS documents as described: observation, regulatory requirement and how the item is to be or is corrected. This item is marked **IN** if the inspection report is correctly scored. This item is marked **IN** if the findings are reviewed with the designee.

OUT This item shall be marked **OUT** if the REHS's inspection report is illegible. This item shall be marked **OUT** if the comments are not concise and do not follow the description: observation, regulation requirement, and correction. This item shall be marked **OUT** if the inspection report is not correctly scored. This item is marked **OUT** if the REHS fails to review the findings with the person in charge or their designee.

NA Marking this is not an option for this item.

III. REHS interprets and applies laws, regulations, policies and procedures correctly.

IN This item is marked **IN** if the REHS correctly understands, interprets and applies the laws, regulations, policies, procedures and marking instructions.

OUT This item shall be marked **OUT** if the REHS's fails to understand, interpret, apply the laws, regulations, policies, procedures and marking instructions.

NA Marking this is not an option for this item.

IV. REHS cites the proper local code provisions for the CDC-identified risk factors and Food Code interventions.

IN This item is marked **IN** if the REHS applies appropriate knowledge of the five CDC risk factors, properly marks the risk factor, and Food Code intervention portion of the inspection report.

OUT This item shall be marked **OUT** if REHS lacks knowledge of the five CDC risk factors, and/or fails to record the number of Risk Factor violations and Food Code interventions on the inspection report.

NA Marking this is not an option for this item.

V. REHS reviews past inspection findings and acts on repeated or unresolved violations.

IN This item is marked **IN** if the REHS is equipped to view previous inspection reports in the field or brings a copy of the previous inspection reports. This item is marked **IN i**f the REHS consistently marks items in accordance with the previous inspection reports **(Repeat**) and .2661.

OUT This item shall be marked **OUT** if the REHS fails to review the previous inspection reports. This item shall be marked **OUT** if the REHS fails to note **Repeat** violations from observations and review of past inspection reports. This item shall be marked **OUT** if the REHS does not follow .2661.

NA Marking this is not an option for this item.

VI. REHS follows through with compliance and enforcement in accordance with the agency's procedures.

IN This item is marked **IN** if the REHS is follows the compliance and enforcement protocol for violations observed.

OUT This item is marked **OUT** if the REHS fails to follow the compliance and enforcement protocol for violations observed.

NA Marking this is not an option for this item.

VII. REHS obtains and documents on-site corrective action for out-of-control risk factors at the time of inspection as appropriate to the violation.

IN This item is marked **IN** if the REHS is familiar with the corrective action and follows the guidance document. This item is marked **IN** if the REHS is adhering to .2661.

OUT This item is marked **OUT** if the REHS is not familiar with the corrective action, is not following the guidance document and fails to follow .2661.

NA Marking this is not an option for this item.

VIII. REHS documents that options for the long-term control of risk factors were discussed with managers when the same out-of-control risk factor occurred on consecutive inspections.

IN This item is marked **IN** if the REHS is familiar with the corrective action and follows the guidance document. This item is marked **IN** if the REHS is adhering to .2661. This item is marked **IN** if the REHS understands effective corrective actions and can work with facility on long term compliance.

OUT This item is marked **OUT** if the REHS is not familiar with the corrective action, is not following the guidance document and fails to follow .2661. This item is marked **OUT** if the REHS fails to understand effective corrective actions or does not work towards long term compliance with facility.

NA Marking this is not an option for this item.

IX. REHS verifies that the establishment is in the proper risk category and that the required inspection frequency is being met.

IN This item is marked **IN** if the REHS inquires about any menu or process changes at the establishment. This item is marked **IN** if the REHS determines that there is a Risk Categorization change or notes categorization is correct at the time of inspection.

OUT This item is marked **OUT** if the REHS fails to inquire about any process or menu changes. This item is marked **OUT** if there are processes occurring that indicate a categorization change and the REHS fails to recognize.

NA Marking this is not an option for this item.

X. REHS files reports and other documents in a timely manner.

IN This item is marked **IN** if the REHS files the inspection report into a database or filing system according to county policy. In absence of a county policy, they must be entered within 5 days of the inspection.

OUT This item is marked **OUT** if the REHS fails to file inspection reports according to county policy or within the 5 days in absence of a county policy.

NA Marking this is not an option for this item.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
POLICY

TITLE: SMOKING IN PROHIBITED PUBLIC PLACES COMPLAINT INVESTIGATIONS

DATE DEVELOPED: 3/13
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/20; 6/22; 6/24

I. POLICY:

Environmental Health shall investigate complaints involving smoking in restaurants, bars and certain lodging settings. Starting in January of 2010, it became unlawful to smoke in enclosed areas of restaurants and bars with the exception of establishments in 130A-496(b). It is also unlawful to smoke in enclosed areas of lodging facilities where food and drink are prepared.

II. PURPOSE:

To enforce the law passed by the General Assembly of the State of North Carolina in order to protect the public's health from the dangers of second-hand tobacco smoke.

III. GUIDELINES:

A. Environmental Health shall receive the complaint regarding the alleged smoking violation.

B. Environmental Health shall log this complaint into **CDP**.

C. The Environmental Health Specialist shall conduct a field visit to determine the validity of the complaint. Upon finding that the complaint is valid, the owner of the establishment will be given an educational letter (see attached) that will describe the law and actions that will be taken in the event of further violations.

D. For the second complaint (first violation), the owner of the establishment is issued a written notice of violation and educational notification of action to be taken in event of further violations.

E. For the third complaint (second violation), the owner of the establishment is issued a second notice of violation along with a written notification of the administrative penalties to be imposed for subsequent violations.

F. For all subsequent violations, the Local Health Director is to be notified and may impose an administrative penalty of not more than two hundred dollars ($200).

G. Each day that a violation occurs may be viewed as a separate and distinct violation.

H. All letters and notices shall be sent by CERTIFIED MAIL or hand delivered.

Rev/di

Rockingham County Department of Health and Human Services

Division of Public Health Services
371 NC HWY 65 ~ P.O. Box 204
Wentworth, NC 27375 – 0204
Phone (336) 342-8140
Fax (336) 342-8356

CERTIFIED MAIL

DATE

_____ Owner
_____Restaurant
_____Road
_____town, NC _____zip

Dear **OWNER**,

On January 2, 2010, a new law went into effect prohibiting smoking in restaurants and bars in North Carolina entitled an ACT TO PROHIBIT SMOKING IN CERTAIN PUBLIC PLACES AND CERTAIN PLACES OF EMPLOYMENT (S.L. 2009-27) referred to as the NC Smoke-Free Restaurants and Bars Law. The Rockingham County Department of Health and Human Services has received a complaint of an alleged violation of the law at _____Restaurant, _____ Road, _____TOWN, North Carolina _____zip.

Under the new law, smoking is prohibited in enclosed areas of bars and restaurants. Smoking is also not allowed in enclosed areas of many lodging establishments that operate a permitted restaurant. A person in charge of a restaurant, bar or lodging establishment that is subject to the law must: 1) post the required no-smoking signs, 2) remove indoor ashtrays and other smoking receptacles and 3) direct any person who is smoking to extinguish the lighted tobacco product.

The following describes the particular alleged violation(s):
_____ GIVE NAME, TITLE AND PLACE OF EMPLOYMENT AND DESCRIBE THE INVESTIGATION. The reported allegations, if true, would constitute violations of the new NC Smoke-free Restaurants and Bar Law.

This letter is <u>not</u> a notice of violation. Instead we are taking the opportunity to provide you with information to help you ensure that your establishment is in compliance with the new law. Violation(s) of the law by the business has the following penalties:

- First violation: the person in violation receives written notice of the person's first violation and notification of action to be taken in the event of subsequent violations.
- Second violation: the person in violation receives a written notice of the person's second violation and notification of administrative penalties to be imposed for third and subsequent violations.
- Third and subsequent violations: the person in violation receives an administrative penalty of not more than two hundred dollars ($200.00). Each day on which a violation of this law or rules occurs may be considered a separate and distinct violation.

Enclosed is basic information about provisions of the law and a business guide with a link to the website www.smokefree.nc.gov where you can find more detailed information. Additionally, to further assist your establishment in complying with the NC Smoke-free Restaurants and Bars Law, a representative from our local health department may follow-up with you to provide educational assistance. Please take advantage of this opportunity to become more familiar with the law. We are available to assist you in bringing your establishment into compliance with the law.

If you have any questions concerning the law or would like to receive additional information, please visit www.smokefree.nc.gov or call the Rockingham County Department of Health and Human Services and speak with the Environmental Health Director or the Environmental Health Programs Coordinator at (336)342-8180.

Sincerely,

Public Health Division Director

Enclosure: Business Guide
SmokeFree.NC.gov

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: STORAGE OF NCDA VIOLATION NOTICES

DATE DEVELOPED: 12/13
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/20

I. POLICY:

NCDA Violation Notices that are received by Environmental Health will be kept on file for a period not less than 3 years.

II. PURPOSE:

To keep on file any NCDA Notices of Violation for future reference as requested by the Food Protection and Facilities Branch of the Environmental Health Section for NC DHHS/Division of Public Health.

III. GUIDELINES:

When a letter of violation is received by Environmental Health, it will be placed in the file in chronological order.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CUSTOM DATA PROCESSING (CDP) INSPECTION SOFTWARE USAGE POLICY

DATE DEVELOPED: 01/14
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

Rockingham County Environmental Health Staff will complete all inspection reports for food service establishments, lodging establishments, institutions, child care centers, school buildings, public swimming pools and tattoo artists on their mobile computers using the Custom Data Processing (CDP) Inspection Software.

II. PURPOSE:

To improve the consistency of inspection reports, decrease the amount of errors on reports, and decrease the amount of time involved in completing an inspection from beginning to end.

III. GUIDELINES:

A. Staff who regularly conduct inspections for food service establishments, lodging establishments, institutions, child care centers, school buildings, public swimming pools and tattoo artists will use CDP mobile software to enter inspections on their mobile computers in the field.

- During inspections, violations and observations will be recorded on a note pad, and the mobile computer used after the inspection to report the findings.

B. Staff who occasionally conduct inspections for food service establishments, lodging establishments, institutions, child care centers, school buildings, public swimming pools and tattoo artists will use the web based CDP software to enter inspections on their computers in the office.

- Paper inspection forms will be used in the field to record findings.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

ENVIRONMENTAL HEALTH FIELD STAFF ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A. The Division of Public Health - 1. Mission, vision, goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B. Review of Policies: Agency – HIPAA – Policies & Procedures – Sign & Date 1. Agency Safety a. Fire prevention and plan b. Smoke sensors c. Fire Extinguishers d. Exit Signs e. Security f. Tornado Plan g. Emergency Preparedness - Environmental Health Disaster Training - Environmental Health Disaster Assistance - Emergency Shelters and Team Assigned		
2. Personal Safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies - Clients - Employees - Staff training for: • HIPAA • Cultural Diversity • Infection Control • Body Mechanics • Buried Utility Line • Field Safety • Safety Procedures (Hazmat)		

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
3. Infection Control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease d. Precautions e. Cleaning Disinfecting, Transporting Equipment f. Storing and Handling Supplies g. Standard Precautions h. Blood borne Pathogens i. Vaccinations • TB Skin Test • Hepatitis B or Waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management k. Identifying, handling, and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment • Boots • Ear Protection • Insect Repellant • N-95- Respirator Mask • Safety Glasses		
4. Community Resources and Collaboration		
5. Continuing Education Requirements		
6. Employee Performance Evaluation		
C. Improving Organizational Performance Measures 1. Call supervisor by 8:00 am if not reporting to work 2. Job Description 3. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Audits c. Incidents Reports d. Bloodborne Pathogen Exposure e. Client Complaints		
D. Preceptor Assigned – works with and under direction of preceptor.		
E. Orientation Period – write in dates (one month)		
F. Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable)		

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
4. Pager system 5. Scope of services and program policy review 6. Service/Program Record a. Documentation System – TRAKiT b. Documentation • How to correct entries • Writing neat and legible • Review record retention guidelines		
G. Environmental Health Performance of Duties 1. Reviews expectations of the assigned role. 2. Reviews state laws and rules, local rules, guidelines, and ordinances for assigned role. 3. Reviews geographical outlines/boundaries of Rockingham County.		
H. Expectations of the Environmental Health Staff Role: • Report to work-site as assigned in a timely manner • Use appropriate communication skills • Document and enter data appropriately • Accounts for all work hours through leave records and time sheets • Reviews and updates job description annually • Adheres to dress code – displaying a professional appearance or worksite appropriate attire • Establishes an effective working relationship with others • Reliable in following procedures/policies • Provides services to clients according to standards, program guidelines and collaborates with other staff or community resources • Treats public with courtesy and respect • Maintains complete confidentiality of client information – where applicable		

Comments: _____

_____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Date Developed: 10/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

Rev/di

ROCKINGHAM COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Environmental Health
Field Staff-On-Site Wastewater

Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The E.H. field staff applies theoretical concepts in collaboration with the county, local, state requirements.						
	B.	The E.H. staff collects and completes data that is comprehensive and accurate.						
	C.	The E.H. staff assists in analyzing data about the community.						
	D.	The E.H. staff collaborates internally and with community and state in order to determine progress toward goal achievement.						
	E.	The E.H. staff participates in program audits to assure quality of services.						
II.	**Performance:**							
	F.	The E.H. staff reports to work-site as assigned in a timely manner.						
	G.	The E.H. staff interacts professionally when interacting with client services.						
	H.	The E.H. staff uses appropriate communication techniques to make client comfortable, addresses client concerns, and makes telephone calls with dignity and respect.						
	I.	E.H. staff member works effectively as a team player with flexibility in work assignments and by maintaining a positive and supportive attitude.						
	J.	E.H. staff adheres to appropriate dress and grooming.						
	K.	E.H. staff maintains a reliable attendance record.						
	L.	E.H. staff uses chain of command for problem resolution.						
	M.	E.H. staff demonstrates ability to retrieve program and statistical information as needed.						
	N.	E.H. staff adheres to agency's policies and procedures - reviews annually						
	O.	E.H. staff properly completes all required documentation on assigned clients within a timely manner using correct terminology and procedures.						
	P.	E.H. staff is knowledgeable and maintains client rights and confidentiality.						
	Q.	At least three hole borings done on each soil-site evaluation.						
	R.	Hole borings are documented properly.						
	S.	Permits are complete with all required information						
	T.	Setbacks are shown on the permit.						
	U.	House/building dimensions are shown.						
	V.	Septic system and repair area sizes are documented on the permit.						
	W.	The permit lists the long-term acceptance rate.						
	X.	Permit is drawn to scale.						

III. Infection Control Measures:											
			Handwashing								
		1.	Washes hands at least 30 seconds under running water.								
		2.	Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.								
		3.	Keep fingers pointed down, lower than wrists to prevent contamination of the arms.								
		4.	Rinse hands under running water allowing water to flow from the upper arm down over the hands.								
		5.	Dry hands thoroughly with a dry paper towel.								
		6.	Use a separate paper towel to turn off the faucet.								
		7.	Use lotion to prevent drying of the skin.								
		8.	Use gel or foam cleanser to wash hands only until you can use running water.								
	A.		Disposal of soiled materials								
	B.		Disposal of excretions								
	C.		Universal Precautions								
	D		Has attended annual training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.								
	E.		Demonstrates an understanding of and practices universal precautions.								
	F.		Demonstrates an understanding of modes of transmission of bloodborne diseases.								
	G.		Demonstrates knowledge and selection of personal protective equipment.								
	H.		Practices handwashing to prevent spread of disease.								
	I.		Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.								
			Standard Precautions								
		1.	Assemble equipment								
		2.	Wash hands								
		3.	Uses protective barrier precautions (mask, protective eyewear, gowns, gloves) as appropriate to prevent contact with client's body/blood fluids – when applicable.								
		4.	Disposes of soiled material properly.								
		5.	Knows location of and usage for spill kit.								
IV. Skills Performance - Body Mechanics											
	A.		Sitting:								
		1.	Position buttocks against the back of chair.								
		2.	Place feet flat on floor at 90 degree angle to lower legs.								
		3.	Flexes hip slightly so knees are higher than ischial tuberosities.								
		4.	Flexes lumbar spine slightly.								
		5.	Flexes elbows and places forearms on armrest, if applicable.								
	B.		Standing:								
		1.	Keeps feet parallel 6 inches to 8 inches apart.								
		2.	Places equal weight on both legs.								
		3.	Flexes knees slightly.								
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.								
	C.		Walking:								

		1.	Assumes the correct standing position.							
		2.	Steps forward a comfortable distance with one leg.							
		3.	Tilts the pelvis slightly forward and downward.							
		4.	Touches floor first with heel then ball of foot to toes.							
		5.	Advances the other arm and leg to promote balance.							
D.		Pulling:								
		1.	Stands close to the object.							
		2.	Places one foot slightly ahead of the other.							
		3.	Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscle.							
E.		Pushing:								
		1.	Places hands on object and flexes the elbows.							
		2.	Leans into the object by shifting weight from back leg to front leg.							
		3.	Applies smooth continuous pressure.							
F.		Stooping:								
		1.	Stands with feet 10-13 inches apart.							
		2.	Places one foot slightly ahead of the other.							
		3.	Lowers self by flexing the knees.							
		4.	Places more weight on front foot than back.							
		5.	Keeps upper body straight (does not bend at the waist).							
		6.	Straightens knees keeping the back straight.							
G.		Lifting and Carrying								
		1.	Assumes stooping position directly in front of the object.							
		2.	Grasps object and tightens abdominal muscles.							
		3.	Stands up straight by straightening the knees.							
		4.	Carries the object close to the body waist high.							

Comments: _____

_____

_____ successfully demonstrates the above criteria in the work setting.
Employee

_____ _____
Employee Signature Date

_____ _____
Reviewer's Signature Date

_____ _____
Employee Signature Date

_____ _____
Reviewer's Signature Date

Issued: 3/02
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

Rev/di

ROCKINGHAM COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Environmental Health
Field Staff-Water/Wells

Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The E.H. field staff applies theoretical concepts in collaboration with the county, local, state requirements.						
	B.	The E.H. staff collects and completes data that is comprehensive and accurate.						
	C.	The E.H. staff assists in analyzing data about the community.						
	D.	The E.H. staff collaborates internally and with community, and state in order to determine progress toward goal achievement.						
	E.	The E.H. staff participates in program audits to assure quality of services.						
II.	**Performance:**							
	F.	The E.H. staff reports to work-site as assigned in a timely manner.						
	G.	The E.H. staff interacts professionally when interacting with client services.						
	H.	The E.H. staff uses appropriate communication techniques to make client comfortable, addresses client concerns, and makes telephone calls with dignity and respect.						
	I.	E.H. staff member works effectively as a team player with flexibility in work assignments and by maintaining a positive and supportive attitude.						
	J.	E.H. staff adheres to appropriate dress and grooming.						
	K.	E.H. staff maintains a reliable attendance record.						
	L.	E.H. staff uses chain of command for problem resolution.						
	M.	E.H. staff demonstrates ability to retrieve program and statistical information as needed.						
	N.	E.H. staff adheres to agency's policies and procedures - reviews annually						
	O.	E.H. staff properly completes all required documentation on assigned clients within a timely manner using correct terminology and procedures.						
	P.	E.H. staff is knowledgeable and maintains client rights and confidentiality.						
	Q.	The Well Construction Permit filled out and complete.						
	R.	The well site maintains proper distances from the septic system.						
	S.	The well maintains proper distances from buildings.						
	T.	The well site maintains proper setbacks from property lines.						
	U.	The well site has proper setbacks to topography problems.						
	V.	The well site maintains proper setbacks from other sources of possible contamination.						
	W.	The permit is drawn to scale.						

	X.	When the well permit is completed as a certificate of completion, all information is complete.							
	Y.	Water collection forms are completed with required information.							
III. Infection Control Measures:									
		Handwashing							
		1. Washes hands at least 30 seconds under running water.							
		2. Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.							
		3. Keep fingers pointed down, lower than wrists to prevent contamination of the arms.							
		4. Rinse hands under running water allowing water to flow from the upper arm down over the hands.							
		5. Dry hands thoroughly with a dry paper towel.							
		6. Use a separate paper towel to turn off the faucet.							
		7. Use lotion to prevent drying of the skin.							
		8. Use gel or foam cleanser to wash hands only until you can use running water.							
	A.	Disposal of soiled materials							
	B.	Disposal of excretions							
	C.	Universal Precautions							
	D	Has attended annual training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.							
	E.	Demonstrates an understanding of and practices universal precautions.							
	F.	Demonstrates an understanding of modes of transmission of bloodborne diseases.							
	G.	Demonstrates knowledge and selection of personal protective equipment.							
	H.	Practices handwashing to prevent spread of disease.							
	I.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.							
		Standard Precautions							
		1. Assemble equipment							
		2. Wash hands							
		3. Uses protective barrier precautions (mask, protective eyewear, gowns, gloves) as appropriate to prevent contact with client's body/blood fluids – when applicable.							
		4. Disposes of soiled material properly.							
		5. Knows location of and usage for spill kit.							
IV. Skills Performance - Body Mechanics									
	A.	Sitting:							
		1. Position buttocks against the back of chair.							
		2. Place feet flat on floor at 90-degree angle to lower legs.							
		3. Flexes hip slightly so knees are higher than ischial tuberosities.							
		4. Flexes lumbar spine slightly.							
		5. Flexes elbows and places forearms on armrest, if applicable.							
	B.	Standing:							
		1. Keeps feet parallel 6 inches to 8 inches apart.							
		2. Places equal weight on both legs.							

		3.	Flexes knees slightly.							
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.							
	C.	Walking:								
		1.	Assumes the correct standing position.							
		2.	Steps forward a comfortable distance with one leg.							
		3.	Tilts the pelvis slightly forward and downward.							
		4.	Touches floor first with heel then ball of foot to toes.							
		5.	Advances the other arm and leg to promote balance.							
	D.	Pulling:								
		1.	Stands close to the object.							
		2.	Places one foot slightly ahead of the other.							
		3.	Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscle.							
	E.	Pushing:								
		1.	Places hands on object and flexes the elbows.							
		2.	Leans into the object by shifting weight from back leg to front leg.							
		3.	Applies smooth continuous pressure.							
	F.	Stooping:								
		1.	Stands with feet 10-13 inches apart.							
		2.	Places one foot slightly ahead of the other.							
		3.	Lowers self by flexing the knees.							
		4.	Places more weight on front foot than back.							
		5.	Keeps upper body straight (does not bend at the waist).							
		6.	Straightens knees keeping the back straight.							
	G.	Lifting and Carrying								
		1.	Assumes stooping position directly in front of the object.							
		2.	Grasps object and tightens abdominal muscles.							
		3.	Stands up straight by straightening the knees.							
		4.	Carries the object close to the body waist high.							

Comments: _____

_____

_____ successfully demonstrates the above criteria in the work setting.
Employee

_____	_____
Employee Signature	Date
_____	_____
Reviewer's Signature	Date
_____	_____
Employee Signature	Date
_____	_____
Reviewer's Signature	Date
_____	_____
Employee Signature	Date
_____	_____
Reviewer's Signature	Date

Issued: 3/02
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Rev/di

ROCKINGHAM COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Environmental Health
Field Staff-Food Establishments/Institutions

Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The E.H. field staff applies theoretical concepts in collaboration with the county, local, state requirements.						
	B.	The E.H. staff collects and completes data that is comprehensive and accurate.						
	C.	The E.H. staff assists in analyzing data about the community.						
	D.	The E.H. staff collaborates internally and with community, and state in order to determine progress toward goal achievement.						
	E.	The E.H. staff participates in program audits to assure quality of services.						
II.	**Performance:**							
	A.	The E.H. staff reports to work-site as assigned in a timely manner.						
	B.	The E.H. staff interacts professionally when interacting with client services.						
	C.	The E.H. staff uses appropriate communication techniques to make client comfortable, addresses client concerns, and makes telephone calls with dignity and respect.						
	D.	E.H. staff works effectively as a team player with flexibility in work assignments and by maintaining a positive and supportive attitude.						
	E.	E.H. staff adheres to appropriate dress and grooming.						
	F.	E.H. staff maintains a reliable attendance record.						
	G.	E.H. staff uses chain of command for problem resolution.						
	H.	E.H. staff demonstrates ability to retrieve program and statistical information as needed.						
	I.	E.H. staff adheres to agency's policies and procedures - reviews annually						
	J.	E.H. staff properly completes all required documentation on assigned clients within a timely manner using correct terminology and procedures.						
	K.	E.H. staff is knowledgeable and maintains client rights and confidentiality.						
	L.	The restaurant/institution was inspected in a systematic manner.						
	M.	Point deductions and comments are consistent with problems observed.						
	N.	Grade forms are filled out with all information required.						
	O.	Grade forms and comment addenda forms are neat and legible.						
	P.	Forms are signed by the Environmental Health Specialist and the establishment Recipient.						
	Q.	E.H. staff use CDP software to track inspections, permits, and other activities.						

III. Infection Control Measures:										
			Handwashing							
		1.	Washes hands at least 30 seconds under running water.							
		2.	Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.							
		3.	Keep fingers pointed down, lower than wrists to prevent contamination of the arms.							
		4.	Rinse hands under running water allowing water to flow from the upper arm down over the hands.							
		5.	Dry hands thoroughly with a dry paper towel.							
		6.	Use a separate paper towel to turn off the faucet.							
		7.	Use lotion to prevent drying of the skin.							
		8.	Use gel or foam cleanser to wash hands only until you can use running water.							
	A.		Disposal of soiled materials							
	B.		Disposal of excretions							
	C.		Universal Precautions							
	D		Has attended annual training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.							
	E.		Demonstrates an understanding of and practices universal precautions.							
	F.		Demonstrates an understanding of modes of transmission of bloodborne diseases.							
	G.		Demonstrates knowledge and selection of personal protective equipment.							
	H.		Practices handwashing to prevent spread of disease.							
	I.		Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.							
			Standard Precautions							
		1.	Assemble equipment							
		2.	Wash hands							
		3.	Uses protective barrier precautions (mask, protective eyewear, gowns, gloves) as appropriate to prevent contact with client's body/blood fluids – when applicable.							
		4.	Disposes of soiled material properly.							
		5.	Knows location of and usage for spill kit.							
IV. Skills Performance - Body Mechanics										
	A.		Sitting:							
		1.	Position buttocks against the back of chair.							
		2.	Place feet flat on floor at 90-degree angle to lower legs.							
		3.	Flexes hip slightly so knees are higher than ischial tuberosities.							
		4.	Flexes lumbar spine slightly.							
		5.	Flexes elbows and places forearms on armrest, if applicable.							
	B.		Standing:							
		1.	Keeps feet parallel 6 inches to 8 inches apart.							
		2.	Places equal weight on both legs.							
		3.	Flexes knees slightly.							
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.							

	C.	Walking:							
		1. Assumes the correct standing position.							
		2. Steps forward a comfortable distance with one leg.							
		3. Tilts the pelvis slightly forward and downward.							
		4. Touches floor first with heel then ball of foot to toes.							
		5. Advances the other arm and leg to promote balance.							
	D.	Pulling:							
		1. Stands close to the object.							
		2. Places one foot slightly ahead of the other.							
		3. Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscle.							
	E.	Pushing:							
		1. Places hands on object and flexes the elbows.							
		2. Leans into the object by shifting weight from back leg to front leg.							
		3. Applies smooth continuous pressure.							
	F.	Stooping:							
		1. Stands with feet 10-13 inches apart.							
		2. Places one foot slightly ahead of the other.							
		3. Lowers self by flexing the knees.							
		4. Places more weight on front foot than back.							
		5. Keeps upper body straight (does not bend at the waist).							
		6. Straightens knees keeping the back straight.							
	G.	Lifting and Carrying							
		1. Assumes stooping position directly in front of the object.							
		2. Grasps object and tightens abdominal muscles.							
		3. Stands up straight by straightening the knees.							
		4. Carries the object close to the body waist high.							

Comments: _____

_____

_____ successfully demonstrates the above criteria in the work setting.
Employee

_____	_____
Employee Signature	Date
_____	_____
Reviewer's Signature	Date
_____	_____
Employee Signature	Date
_____	_____
Reviewer's Signature	Date

Issued: 3/02
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
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Rev/di

ROCKINGHAM COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Environmental Health Director

Competency Skills Checklist

	SUBJECT		DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Environmental Health Director applies theoretical concepts in practice.						
	B.	The Environmental Health Director systematically collects data that is comprehensive and accurate.						
	C.	The Environmental Health Director evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	D.	The Environmental Health Director participates in peer review and program audits to assure quality of services.						
	E.	The Environmental Health Director collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	F.	The Environmental Health Director reports to office as assigned in a timely manner.						
	G.	The Environmental Health Director introduces self to client.						
	H.	The Environmental Health Director uses appropriate communication techniques to make client comfortable, addresses client concerns and telephone calls with dignity and respect.						
	I.	Environmental Health Director effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	J.	Environmental Health Director demonstrates support of agency by involvement in community activities.						
	K.	Environmental Health Director uses chain of command for problem resolution.						
	L.	Environmental Health Director adheres to appropriate dress and grooming.						
	M.	Environmental Health Director maintains a reliable attendance record.						
	N.	Environmental Health Director safely and accurately assists other staff during procedures.						
	O.	Demonstrates ongoing communication with the client and professional staff						
	P.	Properly completes all required documentation on assigned clients within a timely manner using correct medical terminology						
	Q.	Knowledgeable and maintains client rights and confidentiality						
	R.	Implements measures to maintain client confidentiality						
	S.	Demonstrates understanding and implementation of HIPAA compliance						
	T.	Documentation must be timely, accurate and precise						
	U.	Maintain licensure and continuing education requirements of self and staff						

	V.	Adheres to agency policies and procedures – reviews annually						
	W.	Communication						
		1. Listens to others						
		2. Speaks clear and effectively to individuals						
		3. Collaborates and works well with other health care providers, professionals, and community representatives displaying courtesy, tact and patience						
		4. Appropriately introduces self to client in a friendly/ professional manner						
		5. Uses appropriate communication techniques to make the client comfortable						
		6. Addresses client concerns and telephone calls with dignity and respect						
		7. Answers telephone in a professional manner "Environmental Health, this is _____speaking. May I help you?"						
		8. Communicates effectively in writing						
		9. Reviews and critiques others' writing						
	X.	Problem Solving						
		1. Recognizes and defines problems						
		2. Analyzes relevant information						
		3. Encourages alternative solutions and plans to solve problems						
	Y.	Interpersonal Skills						
		1. Considers and responds appropriately to the needs, feelings, capabilities and interests of others						
		2. Provides feedback						
		3. Treats others equitably						
	Z.	Self-Direction						
		1. Realistically assesses own strengths, weaknesses, and impact on others						
		2. Seeks feedback from others						
		3. Works persistently towards a goal						
		4. Demonstrates self confidence						
		5. Invests in self-development						
		6. Manages own time efficiently						
	AA.	Flexibility						
		1. Adapts to change in the work environment						
		2. Effectively copes with stress						
	BB.	Decisiveness						
		1. Takes action and risk when needed						
		2. Makes difficult decisions when necessary						
	CC.	Leadership						
		1. Demonstrates and encourages high standards of behavior						
		2. Adapts leadership style to situations and people						
		3. Empowers, motivates, and guides others						
	DD.	Technical Competence						
		- Demonstrates technical proficiency and an understanding of its impact in areas of responsibility						
	EE.	Managing Diversity						
		1. Recognizes the value of cultural, ethnic, gender and other individual differences						
		2. Provides employment and development opportunities for a diverse workforce						

	FF.	Conflict Management						
		- Anticipates/seeks to resolve confrontations, disagreements, and complaints in a constructive manner						
	GG.	Team Building						
		- Fosters cooperation, communication, and consensus among groups						
	HH.	Influencing/Negotiating						
		1. Networks with and provides information to key groups and individuals						
		2. Appropriately uses negotiation, persuasion, and authority in dealing with others to achieve goals						
	II.	Human Resource Management						
		1. Ensures effective recruitment, selection, training, performance, appraisal, recognition, and corrective/ disciplinary action						
		2. Promotes affirmative employment, good labor relations, and employee well-being						
	JJ.	Creative Thinking						
		1. Develops insights and solutions						
		2. Fosters innovation among others						
	KK.	Planning/Evaluating						
		1. Establishes policies, guidelines, plans, and priorities						
		2. Identifies required resources						
		3. Plans and coordinates with others						
		4. Monitors progress and evaluates outcomes						
		5. Improves organizational efficiency and effectiveness						
	LL.	Community/Client Orientation						
		1. Actively seeks community/client input						
		2. Ensures community/client needs are met						
		3. Continuously seeks to improve the quality of service, products, and processes						
	MM.	Controls/Integrity						
		1. Ensures the integrity of the organization's processes						
		2. Promotes ethical and effective practices						
	NN.	Financial Management						
		1. Prepares and justifies program budget(s)						
		2. Monitors expense						
	OO.	Technology Management						
		1. Encourages staff to stay informed about new technology						
		2. Applies new technology to organizational needs						
		3. Ensures staff members are trained and capable						
	PP.	Vision						
		1. Creates a shared vision of the organization						
		2. Promotes wide ownership						
		3. Champions organizational change						
	QQ.	External Awareness						
		1. Stays informed on laws, policies, politics, administration priorities, trends, special interests, and others						
		2. Considers external impact of statements/actions						
		3. Uses information in decision-making						
II.	**Competencies as Environmental Health Director:**							
	A.	Direct and Manage the Environmental Health Division's Programs						
		1. Plan work operations - Establish priorities, deadlines and goals						

		2. Supervise all Environmental Health program activities and personnel						
		a. Evaluate personnel and programs						
		b. Determine needs within the Division						
		c. Recommend policies and procedures						
		d. Function as the Chief Environmental Health Specialist						
		e. Determine changes needed in personnel, space, equipment, computer programs, resources, policies, procedures, and regulations						
		f. Manage information and review reports						
		g. Coordinate and supervise special projects and program research						
		h. Manage time of personnel						
		i. Approve leave requests						
		3. Determine budgetary requirements						
		a. Submit an annual recommended budget to the Health Director, in consultation with the program staff						
		b. Approve all expenditures within the Environmental Health Section						
		4. Promote and enforce work standards among employees, including:						
		a. Standards of the NC Department of Health and Human Services						
		b. Standards of the Rockingham County Board of Health and Human Services						
		c. Standards of the Rockingham County Board of Commissions						
		d. Standards of the Health Director						
		5. Administer various Environmental Health Programs						
		a. On-site wastewater disposal						
		b. Food establishment, lodging, and institutional sanitation and review of plans						
		c. Swimming pools and tattoo artists						
		d. Vector control						
		e. Environmental communicable disease investigations						
		f. Manufactured home park inspections						
		g. Migrant housing facility inspections						
		h. Well rules enforcement, permitting, inspections and water sample collections						
		i. Emergency response for chemical spills and other environmental cases						
		j. Rabies case consultations with Animal Control, vicious animal cases, and assistance with conduction and promoting the annual rabies clinic						
		k. Lead case investigation and abatement						
		l. Work with the Planning and Building Inspections Department and Tax Department to administer central permitting for property development						
		m. Work with the GIS program to administer a joint-department GIS mapping and information system						
		n. Supervise inspection of Type IV and Type V subsurface sewage disposal						
		o. Prepare a monthly report of Environmental Health Division activities						
III.	**Leadership, Technical Assistance, Assessment, Guidance, and Supervision:**							

	A.	As Chief Environmental Health Specialist, serve as leader, cheerleader, and example for all Environmental Health Specialists						
		1. Assist with evaluations and inspections						
		2. Assess problem cases and assist personnel with difficult decisions and unusual problems						
		3. Assess difficult, unusual, and complex inquiries or requests						
		4. Promote consistency and accuracy among Environmental Health personnel to insure compliance with state and local laws and regulations, and Division of Public Health/Environmental Health policies and procedures						
	B.	Employment of personnel and determining training needs						
		1. Interview and recommend prospective employees to the Health Director						
		2. Determine training needs for Environmental Health in consultation with Program Coordinators						
		3. Ensure that new personnel receive required training and orientation prior to issuance of State authorization to perform their duties and responsibilities						
		4. Monitor training requirements and assess needs of each employee						
		5. Arrange for State orientation of all new employees and authorization by the Regional Environmental Health Specialists for soil, food and lodging, childcare and lead, and pools and tattoo artists						
		6. Establish, evaluate, and supervise in-service training for personnel						
		7. Approve workshop attendance for personnel						
		8. Verify required hours of instructional training for staff members to meet re-certification requirements						
	C.	Review and evaluate daily work activities of Environmental Health Personnel						
		1. Review time and activity reports, and inspection reports						
		2. Consult with OSWW Program Coordinator, Environmental Health Programs Coordinator, and citizens						
		3. For quality assurance and as time permits, perform field work with the staff to evaluate performance and assess training needs						
		4. Performance appraisals are conducted on all personnel as specified by County and Division personnel policies and procedures						
		5. Counsel and conduct initial employee discipline – with oral and written warnings in consultation with the Health Director						
		6. Hear oral grievances, but formal grievances go the Health Director/higher authority by policies and procedures of the County Personnel Ordinance						
		7. Make recommendations for salary adjustments and promotions with final decisions by the Health Director						
		8. Flexibility is maintained to design positions to efficiently provide county services						
		9. Consult with employees about proper completion of job descriptions and review the descriptions for accuracy						
		10. Prepare job descriptions for new positions within the Environmental Health Section						

		11. Ensure that applicants for employment, employees, clients, etc. are not discriminated against on the basis of race, color, national origin, sex, religion, creed, age, political affiliation or physical handicapped in employment or providing services						
		12. Encourage employees to participate in all County programs such as Wellness and Employee Assistance						
	D.	Coordinate and provide indirect supervision to staff members involved in investigation of communicable disease, disease outbreaks, and rabies cases reported to the Division of Public Health						
		1. Serve as a member of the Division Communicable Disease Control Committee which is the agency epidemiological investigative team responsible for investigation, follow-up, and control measures for communicable diseases and outbreaks						
		2. Investigate and manage investigations of potential rabies cases						
		a. Take initial rabies reports, contact people involved, work with nursing staff, local veterinarians, animal control officers, physicians, and the State veterinarian						
		b. Help determine possible exposure and in consultation with the State veterinarian, recommend that people contact a veterinarian for any treatment needed						
		3. Assist with organization, promotion, and coordination of annual rabies clinic						
		a. Distribute and/or supervise distribution of fliers about rabies clinic throughout the county						
		b. Prepare a report about the number of animals vaccinated at the clinic						
		4. Coordinate collection and collect animal specimens from veterinary offices to be sent by courier mail to the NC State Laboratory of Public Health in Raleigh, and report testing results to potential exposure victims						
		5. Work with state and local authorities, the public and news media regarding information about rabies						
	E.	Assistance is provided to staff						
		1. Limited field services are provided to meet workload demands						
		2. Work closely with property owners, managers, contractors, and staff Environmental Health Specialists						
		3. Educate and train field staff on new equipment, processes, and designs						
		4. Assessment and assistance provided in field activities may include						
		a. Complex site evaluations, sizing septic tanks, pump tanks, grease traps, and determining land contours						
		b. Reviewing well permits and water supply systems						
		c. Consulting about water supply problems, and assistance with sample collections and well inspections						
		d. Vector investigations						
	F.	Emergency Response						
		1. Supervise and assist with response to emergencies and training including						
		a. Chemical spills						
		b. Problems with hazardous waste						

		a. Fires affecting food and institutional facilities b. Natural disasters 2. Ensure that proper State and local officials are notified and that the Division of Public Health responsibilities are fulfilled						
	G.	Lead Investigations						
		1. Assist in coordination of investigations by other authorized Environmental Health Specialists 2. Work with the Division of Public Health Lead Investigation Team which includes public health nurses and authorized Environmental Health Specialists						
	H.	Manufactured Home Park Ordinance						
		1. Enforce and supervise enforcement of the Rockingham County Manufactured Home Park Ordinance 2. Review plans for manufactured home parks 3. Inspect manufactured home parks for compliance of wells, water, septic system, and solid waste disposal						
	I.	Water Pollution Control System Operator						
		- Assist a Certified Subsurface Operator with inspections and coordinate with other Certified Subsurface Operators of required inspections of Type IV and V subsurface sewage systems						
IV.	**Communication, Education and Representative of the Environmental Health Section:**							
	A.	Provide citizens, staff, elected officials, and appointed officials with requested information and referrals about Environmental Health issues						
	B.	Represent the Environmental Health Section at public meetings, and in board and committee meetings						
	C.	Environmental Health spokesperson on Environmental Health problems and concerns in the community						
	D.	Consult with the Environmental Health staff and Health Director on Environmental issues						
	E.	Monitor State rule and legislative changes and incorporate them into the Environmental Health program						
	F.	Work for good relationships with public through education and an attitude of help and assistance						
	G.	Develop and plan educational programs for the public in conjunction with the Health Educator						
V.	**General Competencies:**							
	A.	Report to workstation in a timely manner						
	B.	Effectively work as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude						
	C.	Demonstrate support of the agency by involvement in community activities						
	D.	Use chain of command to solve problems						
	E.	Adhere to appropriate dress/grooming code						
	F.	Maintain a reliable attendance record						
	G.	Demonstrate knowledge of the computer system						
	H.	Demonstrate thorough knowledge of typing skills and office procedures						
	I.	Demonstrate ability to retrieve statistical information as needed						
	J.	Adhere to and review annually the policies and procedures						

	K.	Adhere to and review annually the Environmental Health Section policies and procedures						
	L.	Demonstrate understanding and implementation of HIPAA compliance						
	M.	Demonstrate understanding, follow, and set an example to follow safety/body mechanics policies						
VI.	**Infection Control Measures**							
	A.	**Hand Washing**						
		1. Washes hands at least 30 seconds under running water						
		2. Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap						
		3. Keep fingers pointed down, lower than wrists to prevent contamination of the arms						
		4. Rinse hands under running water allowing water to flow from the upper arm down over the hands						
		5. Dry hands thoroughly with a dry paper towel						
		6. Use a separate paper towel to turn off the faucet						
		7. Use lotion to prevent drying of the skin						
		8. Use gel or foam cleanser to wash hands only until you can use running water						
	B.	Disposal of soiled materials						
	C.	Disposal of excretions						
	D.	Universal Precautions						
	E.	Has attended initial training for OSHA Standards 29 CFR 1910.1030 and annually thereafter						
	F.	Demonstrates an understanding of and practices universal precautions						
	G.	Demonstrates an understanding of modes of transmission of blood borne diseases						
	H.	Demonstrates knowledge and selection of personal protective equipment						
	I.	Practices hand washing to prevent spread of disease						
	J.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps container, and soiled supplies						
IV.	**Skills performance – Body Mechanics:**							
	A.	Sitting						
		1. Position buttocks against the back of chair						
		2. Place feet flat on floor at 90-degree angle to lower legs						
		3. Flexes hip slightly so knees are higher than ischial tuberosities						
		4. Flexes lumbar spine slightly						
		5. Flexes elbows and places forearms on armrest, if applicable						
	B.	Standing						
		1. Keeps feet parallel 6 inches to 8 inches apart						
		2. Places equal weight on both legs						
		3. Flexes knees slightly						
		4. Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back						
	C.	Walking						
		1. Assumes the correct standing position						
		2. Steps forward a comfortable distance with						

		one leg 3. Tilts the pelvis slightly forward and downward 4. Touches floor first with heel then ball of foot to toes 5. Advances the other arm and leg to promote balance						
	D.	Pulling						
		1. Stands close to the object 2. Places one foot slightly ahead of the other 3. Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscles						
	E.	Pushing						
		1. Places hands on object and flexes the elbows 2. Leans into the object by shifting weight from back leg to front leg 3. Applies smooth continuous pressure						
	F.	Stooping						
		1. Stands with feet 10-13 inches apart 2. Places one foot slightly ahead of the other 3. Lowers self by flexing the knees 4. Places more weight on front foot than back 5. Keeps upper body straight (does not bend at the waist) 6. Straightens knees keeping the back straight						
	G.	Lifting and Carrying						
		1. Assumes stooping position directly in front of the object 2. Grasps object and tightens abdominal muscles 3. Stands up straight by straightening the knees 4. Carries the object close to the body waist high						

* The program supervisor should store this information within the program.

*Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

_____ successfully demonstrates the above criteria in the work setting.

_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date

Developed: 3/02
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

Rev/di

ROCKINGHAM COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Environmental Health
OSWW Program Coordinator

Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The OSWW Program Coordinator applies theoretical concepts in practice.						
	B.	The OSWW Program Coordinator systematically collects data that is comprehensive and accurate.						
	C.	The OSWW Program Coordinator evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	D.	The OSWW Program Coordinator participates in peer review and program audits to assure quality of services.						
	E.	The OSWW Program Coordinator collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	F.	The OSWW Program Coordinator reports to office as assigned in a timely manner.						
	G.	The OSWW Program Coordinator introduces self to client.						
	H.	The OSWW Program Coordinator uses appropriate communication techniques to make client comfortable, addresses client concerns and answers telephone calls with dignity and respect.						
	I.	The OSWW Program Coordinator effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	J.	The OSWW Program Coordinator demonstrates support of agency by involvement in community activities.						
	K.	The OSWW Program Coordinator uses chain of command for problem resolution.						
	L.	The OSWW Program Coordinator adheres to appropriate dress and grooming.						
	M.	The OSWW Program Coordinator maintains a reliable attendance record.						
	N.	The OSWW Program Coordinator safely and accurately assists other staff during procedures.						
	O.	Demonstrates ongoing communication with the client and professional staff						
	P.	Properly completes all required documentation on assigned clients within a timely manner using correct terminology						
	Q.	Knowledgeable and maintains client rights and confidentiality						
	R.	Implements measures to maintain client confidentiality						
	S.	Demonstrates understanding and implementation of HIPAA compliance						
	T.	Documentation must be timely, accurate and precise						

	U.	Maintains registration and continuing education requirements						
	V.	Adheres to agency policies and procedures – reviews annually						
	W.	Communication 1. Listens to others 2. Speaks clear and effectively to individuals 3. Collaborates and works well with other health care providers, professionals, and community representatives displaying courtesy, tact and patience 4. Appropriately introduces self to client in a friendly/professional manner 5. Uses appropriate communication techniques to make the client comfortable 6. Addresses client concerns and telephone calls with dignity and respect 7. Answers telephone in a professional manner a. Environmental Health, this is _____speaking. May I help you? 8. Communicates effectively in writing 9. Reviews and critiques others' writing						
	X.	Problem Solving 1. Recognizes and defines problems 2. Analyzes relevant information 3. Encourages alternative solutions and plans to solve problems						
	Y.	Interpersonal Skills 1. Considers and responds appropriately to the needs, feelings, capabilities and interests of others 2. Provides feedback 3. Treats others equitably						
	Z.	Self-Direction 1. Realistically assesses own strengths, weaknesses, and impact on others 2. Seeks feedback from others 3. Works persistently towards a goal 4. Demonstrates self confidence 5. Invests in self-development 6. Manages own time efficiently						
	AA.	Flexibility 1. Adapts to change in the work environment 2. Effectively copes with stress						
	BB.	Decisiveness 1. Takes action and risk when needed 2. Makes difficult decisions when necessary						
	CC.	Leadership 1. Demonstrates and encourages high standards of behavior 2. Adapts leadership style to situations and people 3. Empowers, motivates, and guides others						
	DD.	Technical Competence - Demonstrates technical proficiency and an understanding of its impact in areas of responsibility						
	EE.	Managing Diversity 1. Recognizes the value of cultural, ethnic, gender and						

		other individual differences 2. Provides employment and development opportunities for a divers workforce						
	FF.	Conflict Management - Anticipates/seeks to resolve confrontations, disagreements, and complaints in a constructive manner						
	GG.	Team Building - Fosters cooperation, communication, and consensus among groups						
	HH.	Influencing/Negotiating 1. Networks with and provides information to key groups and individuals						
		2. Appropriately uses negotiation, persuasion, and authority in dealing with others to achieve goals						
	II.	Human Resource Management 1. Assists in effective recruitment, selection, training, performance, appraisal, recognition, and corrective/disciplinary action						
		2. Promotes affirmative employment, good labor relations, and employee well-being						
	JJ.	Creative Thinking 1. Develops insights and solutions						
		2. Fosters innovation among others						
	KK.	Planning/Evaluating 1. Assists in establishing policies, guidelines, plans, and priorities						
		2. Identifies required resources						
		3. Plans and coordinates with others						
		4. Monitors progress and evaluates outcomes						
		5. Improves organizational efficiency and effectiveness						
	LL.	Community/Client Orientation 1. Actively seeks community/client input						
		2. Ensures community/client needs are met						
		3. Continuously seeks to improve the quality of service, products, and processes						
	MM.	Controls/Integrity 1. Assists in ensuring the integrity of the organization's processes						
		2. Promotes ethical and effective practices						
	NN.	Financial Management 1. Assists in preparing and justifying the program budget(s)						
		2. Monitors expense						
	OO.	Technology Management 1. Encourages staff to stay informed about new technology						
		2. Applies new technology to organizational needs						
		3. Ensures staff members are trained and capable						
	PP.	Vision 1. Assists in creating a shared vision of the organization						
		2. Promotes wide ownership						
		3. Champions organizational change						
	QQ.	External Awareness 1. Stays informed on laws, policies, politics, administration priorities, trends, special interests, and						

		others 2. Considers external impact of statements/actions 3. Uses information in decision-making						
II.	**General Performance:**							
	A.	At least three hole borings done on each soil-site evaluation						
	B.	Hole borings are documented properly						
	C.	Permits are complete with all required information						
	D.	Setbacks are shown on the permit						
	E.	House/building dimensions are shown						
	F.	Septic system and repair area sizes are documented on the Permit						
	G.	The permit lists the long-term acceptance rate						
	H.	Septic permit is drawn to scale						
	I.	The Well Construction Permit is filled out and complete						
	J.	The well site maintains proper distances from the septic system						
	K.	The well maintains proper distances from buildings						
	L.	The well site has proper setbacks from property lines						
	M	The well site has proper setbacks from topography problems						
	N.	The well site maintains proper setbacks from other sources of possible contamination						
	O.	The well permit is drawn to scale						
	P.	When the well permit is completed as a certificate of completion, all information is complete						
	Q.	Water collection forms are completed with required information						
III.	**Competencies as Soil Scientist/Field Supervisor:**							
	A.	Manages on-site water protection programs: 1. Plan work operations - Establish priorities, deadlines and goals						
		2. Manages field work of on-site water protection personnel						
		a. Evaluate personnel and programs						
		b. Determine needs						
		c. Recommend policies and procedures						
		d. Determine in coordination with Environmental Health Director changes needed in personnel, space, equipment, computer programs, resources, policies, procedures, and regulations						
		e. Manage information and review reports						
		f. Manage time of personnel						
		3. Determine budgetary requirements - Submit an annual recommended budget to the Environmental Health Director, in consultation with the program staff						
		4. Promote and enforce work standards among employees, including:						
		a. Standards of the Department of Health and Human Services						
		b. Standards of the Rockingham County Board of Health and Human Services						
		c. Standards of the Rockingham County Board of Commissions						
		d. Standards of the Environmental Health Director						

		e. Standards of the Health Director						
		5. Assist in administering various on-site water protection programs						
		a. On-site wastewater disposal						
		b. Solid waste complaints and enforcement						
		c. Vector control						
		d. Manufactured home park inspections						
		e. Migrant housing facility inspections						
		f. Well rules enforcement, permitting, inspections and water sample collections						
		g. Emergency response for chemical spills and other environmental cases						
		h. Work with the Planning and Building Inspections Department and Tax Department to administer central permitting for property development.						
		i. Work with the GIS program to administer a joint-department GIS mapping and information system						
		j. Manages Type IV and Type V subsurface sewage disposal inspections as a Certified Water Pollution Control System Operator						
IV.	**Leadership, Technical Assistance, Assessment, Guidance, and Supervision:**							
	A.	Serve as leader, cheerleader, and example for all Environmental Health Specialists						
		1. Assist with evaluations and inspections						
		2. Assess problem cases and assist personnel with difficult decisions, and unusual problems						
		3. Assess difficult, unusual and complex inquiries or requests						
		4. Promote consistency and accuracy among Environmental Health personnel to insure compliance with state and local laws and regulation, and Division of Public Health/Environmental Health policies and procedures						
	B.	Employment of personnel and determining training needs						
		1. Assist in the interview and recommend prospective employees to the Environmental Health Director						
		2. Determine training needs for Environmental Health in consultation with the Environmental Health Director						
		3. Ensure that new personnel receive required training and orientation prior to issuance of State authorization to perform their duties and responsibilities						
		4. Monitor training requirements and assess needs of each employee						
		5. Assist in arranging for State orientation of all new employees and authorization by the Regional Environmental Health Specialists for soil, wastewater and well water						
		6. Evaluate and perform in-service training for personnel						
		7. Assist in approval of workshop attendance for personnel						
		8. Verify required hours of instructional training for staff members to meet re-certification requirements						

	C.	Review and evaluate daily work activities of Environmental Health personnel 1. Review time and activity reports, inspection reports						
		2. Consult with Environmental Health Director, Environmental Health Programs Coordinator and citizens						
		3. For quality assurance and as time permits, perform field work with the staff to evaluate performance and assess training needs						
		4. Hear oral grievances, but formal grievances go the Environmental Health Director and Health Director/higher authority by policies and procedures of the County Personnel Ordinance						
		5. Make recommendations for salary adjustments and promotions						
		6. Flexibility is maintained to design positions to efficiently provide county services						
		7. Assist in preparation of job descriptions for new positions within the on-site water protection program						
		8. Ensure that applicants for employment, employees, clients, etc. are not discriminated against on the basis of race, color, national origin, sex, religion, creed, age, political affiliation or physical handicapped in employment or providing services						
		9. Encourage employees to participate in all County programs such as Wellness and Employee Assistance						
	D.	Assistance is provided to staff 1. Field services are provided to meet workload demands						
		2. Work closely with property owners, managers, contractors and staff Environmental Health Specialists						
		3. Educate and train field staff on new equipment, processes, and designs						
		4. Assessment and assistance provided in field activities may include a. Complex site evaluations, sizing septic tanks, pump tanks, grease traps, and determining land contours						
		b. Reviewing well permits and water supply systems						
		c. Consulting about water supply problems, and assistance with sample collections and well inspections						
		d. Vector investigations						
	E.	Emergency Response 1. Assist with response to emergencies and training including a. Chemical spills						
		b. Problems with hazardous waste						
		c. Fires affecting food and institutional facilities						
		d. Natural disasters						
		2. Ensure that proper State and local officials are notified and that Division of Public Health responsibilities are fulfilled						
	F.	Manufactured Home Park Ordinance 1. Enforce the Rockingham County Manufactured Home Park Ordinance						
		2. Review plans for manufactured home parks						

		3. Inspect manufactured home parks for compliance of wells, water, septic system, and solid waste disposal						
	G.	Water Pollution Control System Operator - As a Certified Subsurface Operator, inspections are conducted and coordinated with other Certified Subsurface Operators of required inspections of Type IV and V subsurface sewage systems						
V.	**Communication, Education and Representative of Soil and On-site Water Protection:**							
	A.	Provide citizens, staff, elected officials, and appointed officials with requested information and referrals about soil and on-site water and wastewater issues						
	B.	Represent Environmental Health at public meetings, and in board and committee meetings						
	C.	Consult with the Environmental Health staff and Environmental Health Director on Environmental issues						
	D.	Monitor state rule and legislative changes and incorporate them into the Environmental Health program in consultation with Environmental Health Director						
	E.	Work for good relationships with public through education and an attitude of help and assistance						
VI.	**General Competencies:**							
	A.	Report to workstation in a timely manner						
	B.	Effectively work as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude						
	C.	Demonstrate support of the agency by involvement in community activities						
	D.	Use chain of command to solve problems						
	E.	Adhere to appropriate dress/grooming code						
	F.	Maintain a reliable attendance record						
	G.	Demonstrate knowledge of the computer system						
	H.	Demonstrate thorough knowledge of typing skills and office procedures						
	I.	Demonstrate ability to retrieve statistical information as needed						
	J.	Adhere to and review annually the policies and procedures with the Environmental Health Director						
	K.	Demonstrate understanding and implementation of HIPAA compliance						
	L.	Demonstrate understanding, follow, and set an example to follow safety/body mechanics policies						
VII.	**Infection Control Measures:**							
	A.	Hand washing 1. Washes hands at least 30 seconds under running water 2. Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap 3. Keep fingers pointed down, lower than wrists to prevent contamination of the arms 4. Rinse hands under running water allowing water to flow from the upper arm down over the hands 5. Dry hands thoroughly with a dry paper towel 6. Use a separate paper towel to turn off the faucet 7. Use lotion to prevent drying of the skin							

		8. Use gel or foam cleanser to wash hands only until you can use running water						
	B.	Disposal of soiled materials						
	C.	Disposal of excretions						
	D.	Universal Precautions						
	E.	Has attended initial training for OSHA Standards 29 CFR 1910.1030 and annually thereafter						
	F.	Demonstrates an understanding of and practices universal precautions						
	G.	Demonstrates an understanding of modes of transmission of blood borne diseases						
	H.	Demonstrates knowledge and selection of personal protective equipment						
	I.	Practices hand washing to prevent spread of disease						
	J.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps container, and soiled supplies						
VIII.	**Skills performance – Body Mechanics:**							
	A.	Sitting						
		1. Position buttocks against the back of chair						
		2. Place feet flat on floor at 90-degree angle to lower legs						
		3. Flexes hip slightly so knees are higher than ischial tuberosities						
		4. Flexes lumbar spine slightly						
		5. Flexes elbows and places forearms on armrest, if applicable						
	B.	Standing						
		1. Keeps feet parallel 6 inches to 8 inches apart						
		2. Places equal weight on both legs						
		3. Flexes knees slightly						
		4. Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back						
	C.	Walking						
		1. Assumes the correct standing position						
		2. Steps forward a comfortable distance with one leg						
		3. Tilts the pelvis slightly forward and downward						
		4. Touches floor first with heel then ball of foot to toes						
		5. Advances the other arm and leg to promote balance						
	D.	Pulling						
		1. Stands close to the object						
		2. Places one foot slightly ahead of the other						
		3. Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscles						
	E.	Pushing						
		1. Places hands on object and flexes the elbows						
		2. Leans into the object by shifting weight from back leg to front leg						
		3. Applies smooth continuous pressure						
	F.	Stooping						
		1. Stands with feet 10-13 inches apart						
		2. Places one foot slightly ahead of the other						
		3. Lowers self by flexing the knees						
		4. Places more weight on front foot than back						
		5. Keeps upper body straight (does not bend at the waist)						
		6. Straightens knees keeping the back straight						

	G.	Lifting and Carrying 1. Assumes stooping position directly in front of the object 2. Grasps object and tightens abdominal muscles 3. Stands up straight by straightening the knees 4. Carries the object close to the body waist high						

* The program supervisor should store this information within the program.

*Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

_____ successfully demonstrates the above criteria in the work setting.

_____ _____
Employee Signature & Date Reviewer's Initials & Date

_____ _____
Employee Signature & Date Reviewer's Initials & Date

_____ _____
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Developed: 3/02
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

/di

Rockingham County Department of Health and Human Services

Environmental Health Section

CLIENT SATISFACTION SURVEY

Food, Lodging, and Institutional Inspections

In an effort to continuously provide our clients with the highest quality of service possible, we find your opinion extremely important. Please take a few minutes to answer the following questions. When complete, simply place in the mail to send it back to us.

1. Were you treated courteously by the Environmental Health Staff? ☐ Yes ☐ No
2. If you applied for a Food Establishment/ Lodging Plan Review, did you receive the assistance you needed to complete your application? ☐ Yes ☐ No
3. During the most recent inspection of your Food/Lodging Establishment, did the Environmental Health Specialist ask you or a manager to be present as the inspection was conducted? ☐ Yes ☐ No
4. If you answered "yes" to the previous question, did you observe similar items of deficiency where points were deducted? ☐ Yes ☐ No
5. Were the inspection results explained at the conclusion of the inspection? ☐ Yes ☐ No
6. Were you provided corrective action where points were deducted? ☐ Yes ☐ No
7. If you applied for a new permit, were you treated courteously by the Central Permitting Technician? ☐ Yes ☐ No

Rockingham County Department of Health and Human Services
Environmental Health Section
CLIENT SATISFACTION SURVEY
Food, Lodging, and Institutional Inspections

In an effort to continuously provide our clients with the highest quality of service possible, we find your opinion extremely important. Please take a few minutes to answer the following questions. When complete, simply place in the mail to send it back to us.

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3. During the most recent inspection of your Food/Lodging Establishment, did the Environmental Health Specialist ask you or a manager to be present as the inspection was conducted? ☐ Yes ☐ No
4. If you answered "yes" to the previous question, did you observe similar items of deficiency where points were deducted? ☐ Yes ☐ No
5. Were the inspection results explained at the conclusion of the inspection? ☐ Yes ☐ No
6. Were you provided corrective action where points were deducted? ☐ Yes ☐ No
7. If you applied for a new permit, were you treated courteously by the Central Permitting Technician? ☐ Yes ☐ No

Rockingham County Department of Health and Human Services
Environmental Health Section
CLIENT SATISFACTION SURVEY
Food, Lodging, and Institutional Inspections

In an effort to continuously provide our clients with the highest quality of service possible, we find your opinion extremely important. Please take a few minutes to answer the following questions. When complete, simply place in the mail to send it back to us.

1. Were you treated courteously by the Environmental Health Staff? ☐ Yes ☐ No
2. If you applied for a Food Establishment/ Lodging Plan Review, did you receive the assistance you needed to complete your application? ☐ Yes ☐ No
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Rockingham County Department of Health and Human Services

Environmental Health Section
CLIENT SATISFACTION SURVEY
Soil-Wastewater or Well and Water Inspections

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4. Were you able to consult with or meet an Environmental Health Specialist? ❒ Yes ❒ No
5. Were your services provided in a timely manner? ❒ Yes ❒ No
6. Were your questions answered by the Environmental Health Staff member? ❒ Yes ❒ No
7. If you received a denial letter, were you given alternatives? ❒ Yes ❒ No

Rockingham County Department of Health and Human Services

Environmental Health Section
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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

FAMILY PLANNING POLICIES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: FAMILY PLANNING PROGRAM

DATE DEVELOPED: 1/94; 5/96
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/24

I. POLICY:

The Division of Public Health Services' Family Planning Program provides services to eligible clients including adolescents. The primary mission of the Family Planning Program is to **help clients plan their families** and improve selected health practices among low-income families.

II. PURPOSE:

A. The Family Planning Program supports a wide range of preventive care that is critical to the reproductive and sexual health of men and women. Family Planning services provide the delivery of reproductive and related preventive health services including patient education and counseling: physical examinations; laboratory testing; basic infertility services; cervical and breast cancer screening; sexually transmitted **infection** (STI) **and Human Immunodeficiency Virus (HIV)** prevention education, testing, treatment and referral, preconception health counseling; achieving pregnancy counseling; pregnancy testing and counseling; training on reproductive life planning skills; education regarding and provision of a wide range of contraceptive methods; and emergency contraception. If the Family Planning clinic is unable to provide access to a specifically requested acceptable and effective medically approved family planning method, the clinic must provide a prescription to the client for their chosen method or provide the client with a referral to another provider for the chosen method, as requested. These services promote self-determination in matters of reproductive health. They help reduce infant mortality and morbidity by decreasing the number of unplanned pregnancies and the poor health outcomes associated with them. These services also reduce the incidence of high risk men's and women's health care by providing access to primary and preventive care. They lower health care costs by reducing abortions and preventing costly high-risk pregnancies and their sequela.

B. To improve the health status of women before pregnancy, to improve pregnancy outcomes and to **assist clients in preventing pregnancy when pregnancy is not desired**.

C. The Rockingham County Division of Public Health Services shall demonstrate compliance with the 10A NCAC 46.0206 for the provision of

Family Planning Services. The North Carolina Administrative Code requires the Division of Public Health Services to provide, contract for, or certify the availability of Family Planning services for all individuals who request these services. Title X services must be provided without the imposition of any durational residency requirement or requirement that the client be referred by a physician. The Division of Public Health Services shall ensure:

1. The client's written informed voluntary consent (written in a language understood by the client or translated and witnessed by an interpreter) to receive services such as examinations, laboratory tests, and treatment must be obtained prior to the client receiving any clinical services. The general consent must include a statement that receipt of Family Planning services is not a prerequisite to receipt of any other services offered in the health department. The general consent for services does not have to be signed annually; only if the form is revised or if the client has not been seen for Family Planning services in 3 years shall it be re-signed. **The Division of Public Health Services' Family Planning program will utilize the state general consent form (DHHS-4112; DHHS-4112S) to capture client general consent for Family Planning services.**

   The Division of Public Health Services' Family Planning program will utilize the **state's** contraceptive method specific consent form and obtain client consent/signature indicating chosen method and understanding of risks/benefits/ side effects before a prescription/ non-prescription contraceptive method is provided. Contraceptive method specific consent shall be signed/re-signed upon initiation of a new method, lapse of method **greater than 1 year** and choosing to restart, when the client chooses to change to a different method or when the form is revised.

2. The Division of Public Health Services shall emphasize provision of Family Planning services to individuals who would not otherwise have access to contraceptive services in the community. All family planning services provided are client-centered, culturally and linguistically appropriate, inclusive, and trauma informed**.**

3. The Division of Public Health Services **shall maintain a fee schedule and schedule of discounts (sliding fee scale) for Family Planning services that will be updated annually.**

D. The Family Planning program will strive to improve pregnancy outcomes and improve the health status of women before pregnancy by meeting the following county-specific outcome objectives set forth by the North

Carolina **Reproductive** Health Branch **(RHB) of the Women, Infant, and Community Wellness Section (WICWS)** by:

1. Increasing the number of family planning patients,
2. **Increasing the number of adolescent patients ages 15-19,**
3. **Reducing the number of repeat pregnancy age 17 and under,**
4. Increasing access to the most effective contraceptives,
5. **Ensuring at least 90% of family planning clients served are at or below 200% of federal poverty level,**
6. **Ensuring at least 85% of female family planning clients ages 15-24 are screened for chlamydia.**

III. GUIDELINES:

A. Eligibility:

1. Individuals with family incomes at or below 100% of Federal Poverty Level are not charged for services. Individuals with family incomes between 101% to 250% of the Federal Poverty Level are provided services under a schedule of discounts based on ability to pay; clients are charged **in accordance with this** sliding fee scale. Eligibility for discounts for un-emancipated minors who receive confidential services must be based on the income of the minor. Eligibility for discounts for other clients requesting confidential services are based on the income of the client. Individuals of families, whose income exceeds 250% of the Federal Poverty Level, receive charges made in accordance with a fee schedule set to recover the reasonable cost of providing the services. (See Family Planning Title X Funding Policy, FP-13)

2. In order to provide continuity of care, women who have received permanent sterilization who were current clients of the Family Planning clinic may receive Family Planning preventative services for one visit as they transition to other care. Women are encouraged to seek services through other providers such as BCCCP or Adult Health Program. Clients who have had a hysterectomy or who are menopausal should be referred, based on eligibility, to a private medical provider of choice, BCCCP or Adult Health Program.

3. These services and care must be provided in a manner that does not discriminate against any individual based on religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status. The Division of Public Health Services will increase staff

awareness of client disparities and health status and delivery of health services **among the community served, including special populations such as LGBTQ, physically disabled, limited English proficiency, etc.,** through education, annual training and review of policy at orientation and annually.

4. The acceptance of Family Planning services must be solely on a voluntary basis. Individuals must not be subjected to coercion to receive services or to use or not to use any particular Family Planning contraceptive method. The Family Planning Program promotes customer friendly services for clients served. Staff may be subject to prosecution under Federal Law **and fined or imprisoned** if they coerce or endeavor to coerce any person to undergo an abortion or sterilization procedure.

5. Acceptance of Family Planning services must not be a prerequisite to eligibility for receipt of any other services or assistance from or participation in any other program that is offered by the Division of Public Health Services.

6. Signage is visible/accessible for all clients in both electronic and print format in the clinic area acknowledging that Family Planning services are provided to all clients requesting services without regard to religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristic(s), number of pregnancies, or martial status.

7. Signage is visible/accessible for all clients in both electronic and print format in the clinic area indicating that interpreter services are available. (These interpreter services are provided to clients at no charge to the client.)

8. Signage is visible/accessible for all clients in both electronic and print format in the clinic area stating that charges incurred in the Family Planning Program will be based in accordance with a schedule of discounts based on ability to pay and family size, except for persons from families whose annual income exceeds 250% of the federal poverty level. (§59.5 & §59.10 in the Family Planning Regulations and Title VI of the Civil Rights Act of 1964 through Executive Order 13166.)

9. Signage is visible/accessible for all clients in both electronic and print format in the clinic area indicating that all services are provided with assurance of the client's privacy/ confidentiality. (See Client Right to Receive The RCDHHS Notice of Privacy Practices Policy, and Confidentiality of Individually Identified Health Information Policy.) **Additionally, signage alerts clients to the**

availability of "confidential" services that are based solely on the client's income as a family of one and assure no mail is sent to the client's home.

10. Signage is visible/accessible for all clients in both electronic and print format in the clinic area indicating the Division of Public Health Services accepts donations from Family Planning clients. Clients are not pressured to make donations, and donations are not a prerequisite to the provision of services or supplies.

11. A patient bill of rights which outlines patient rights and responsibilities is visible and posted in the clinical area.

B. Recruitment:

Community is informed of Family Planning Services through outreach programs. Client referrals are received from physicians, hospitals, various community agencies, and through intra-agency programs of the Division of Public Health Services.

C. Clinic Schedule:

1. Family Planning services are offered by appointment. Appointments are made through the Agency Electronic Health Record (EHR) system. Management support staff or the EHR Communicator Application will remind clients of their appointments prior to the appointment date.

2. Appointments can be scheduled Monday - **Wednesday** between 8:00 a.m. - 5:00 p.m. Appointments **can be** scheduled Thursdays between 8:00 a.m. - **8:00 p.m**. **and on Fridays 8:00 a.m. -1:00 p.m.**

D. Family Planning Program Methods:

1. Methods of contraception offered through the Family Planning Program based on availability include natural family planning, oral contraceptive pills, Depo Provera, diaphragms, condoms, Intrauterine devices, Nuva Ring, and Nexplanon. Emergency Contraception is available as indicated but is not considered a method of contraception. Abortion is not a contraceptive method for birth control and no Title X funds will be used to support abortion services.

2. Female Family Planning clients who request sterilization and are 21 years of age or older are referred to a local Gynecological consulting physician if covered by insurance or Medicaid. Male clients who have insurance or Medicaid and are requesting sterilization are referred to local Urology providers. Uninsured male clients are

referred to the Regional Vasectomy Program when funds are available. Uninsured male and female clients are provided with information/referred to Department of Social Services for possible funding through Title XX and to apply for "Be Smart" Family Planning Medicaid Program or Medicaid coverage **to aid in sterilization service coverage**.

E. Staff Qualifications:

1. The Family Planning Program is staffed by an Advanced Practice provider, Medical Office Assistant/Foreign Language Interpreter, Laboratory Technician, Public Health Nurses, and Management Support Staff.

2. The Division of Public Health Services assures staff awareness of health disparities, health equity and social determinants of health, as well as service deliveries, especially disparities related to race/ethnicity, disability, and socioeconomic status through annual training. Cultural competency training is also included in orientation for new staff as well as annual training for existing staff.

3. The Advanced Practice provider and nurses function according to local protocols and standing orders. (See standing orders and Advanced Practice provider/Physician Assistant protocols).

4. **The Medical Director, a physician**, reviews/signs all clinical policies/protocols for Family Planning program.

5. All standing orders or protocols developed for nurses in support of Family Planning program must include components required by the North Carolina Board of Nursing. Rockingham County Division of Public Health maintains a policy that supports nurses working under standing orders (see Standing Orders policy NUR-19).

F. Purchasing/Providing/Charging for Various Types of Contraception:

1. The Division of Public Health Services will provide oral contraceptive/Nuva Ring supplies according to sliding scale fee.

   a. Clients are advised to be responsible for their birth control supplies. If a sliding fee scale uninsured client requests replacement of contraceptive due to lost supplies or requests greater than 13 packages of monthly contraceptive/year with $\geq$ 2 occurrences within 2 years, the Division of Public Health Services staff will provide the following counseling:

      - The client will be counseled on their chosen method including necessity of compliance/use.
      - Method change options if indicated with assessment of

problematic supply loss or replacement requests.
- The client is advised of fees/charged for the replacement of pills on sliding fee scale.

b. Clients with Medicaid or private insurance coverage are given a prescription for birth control pills, Nuva Ring, Contraceptive Patch, or Emergency Contraceptive to have filled at an outside pharmacy of their choice **unless these clients indicate there are barriers to accessing these methods through a pharmacy**.

c. Clients under the age of 18 years who are Medicaid eligible and are requesting confidential Family Planning services **and other confidential clients** may receive oral contraceptives, Nuva Ring or Emergency Contraceptives from the Division of Public Health Services' Pharmacy **if obtaining the medications from the pharmacy would jeopardize confidentiality**.

2. The Division of Public Health Services will offer a broad range of acceptable and effective medically approved contraception and services either on site or by referral. Where resources are limited, the Division of Public Health Services may offer an alternative, less expensive form of contraception. If the client requests a specific form of contraception unavailable through Family Planning Program, the Division of Public Health Services may offer a list of providers that provide the **contraceptive method** requested or provide a prescription.

3. The Division of Public Health Services will maintain a tracking system of current inventory to assure that there are enough drugs and supplies to meet the needs of the population served. This system will include the tracking of lot numbers, NDC numbers, expiration dates, dates received and current amount available for each birth control method offered by the agency. Contraceptive supplies are purchased through the Federal Drug Pricing Program (340b). (See Pharmacy Policy-11 on Procurement/Inventory Control/Property Management for Title X and federal grant requirements.)

G. Initial and **Annual** Preventive Visits:

1. All clients are offered a preventative appointment every 12 months. The Management Support Staff will register the client and initiate the encounter form. The following paper or Electronic Health Record (EHR) forms will be generated within the medical record or in the clinic interview room as indicated:

a. General Consent for Family Planning Services;

b. The Family Planning **Biological** Female (Male) Reproductive Health History data is incorporated into the client history section of the EHR. Family Planning and Reproductive Health **Biological** Female (Male) Flow Sheet;
c. Division of Public Health Services Clinic Routine form;
d. Syphilis Serology Lab Form (CDC recommends screening MSM, those living with HIV, commercial sex workers, persons who exchange sex for drugs, those in adult correctional facilities and those living in communities with high prevalence) annually and as indicated;
e. HIV Testing Form (CDC recommends all clients aged 13-64 be screened annually and all persons likely to be at high risk for HIV be rescreened at least annually; Injection Drug User (IDU) and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, MSM or heterosexual person who themselves or sex partners have had more than one sex partner since their most recent HIV test) as indicated.
f. Chlamydia/Gonorrhea Detection Form (Required if ≤25 years of age and as indicated for those 26 and older and have symptoms, sex partner referral, or high-risk history (such as new partner or multiple partners) per CDC guidelines and/or with IUD insertion if required per CDC's STD Screening Guidelines (U.S. Selected Practice Recommendations [SPR], **2021**) as indicated;
g. Pap Smear Screening Form (clients 21 years of age or older) as indicated;
h. Consent form for client's chosen method of birth control;
i. If client requests no mail to be sent to her address, this information is documented in the record;
j. If client requests to receive no telephone messages **or mail** at the home address, they are requested to provide a confidential telephone number where a message may be left to contact the Family Planning staff;
k. Clients will be given age-appropriate, client centered, evidence based educational materials tailored to the client's stated visit purpose and assessed needs;

2. History –All Family Planning clients will receive a comprehensive history upon initiation of services with review/update of the history annually with preventive visits and inter-periodically as indicated. All clients must be assessed for a primary care provider as part of their health history. If a client does not have a primary care provider, a referral should be offered and documented in the medical record.

a. Medical – Acute and chronic medical conditions including significant illnesses; hospitalizations, surgery, blood transfusion, or exposure to blood products, gynecological conditions; menstrual/obstetrical history; PAP history (date of last PAP, and if abnormal PAP, treatment); urological conditions; contraceptive use past and present (including adverse effects); and pertinent history of immediate family members. **(R)**

b. Allergy **(R)**

c. Medications, current use of over the counter/prescription

d. Social/sexual history **(R)**

- Pertinent partner(s) history
- Extent of use of tobacco, alcohol, and other drugs
- Sexual History and Social History
- If Postpartum, client must also be screened with the 5Ps screening tool

e. Depression Screening – Modified PHQ-2 questions:

- A female/male reproductive health history is completed during initiation of FP services and updated annually at preventive visits. This reproductive health history includes a limited mental health/depression screening. This limited mental health/depression screening is also completed at the pregnancy testing/counseling service visit. A "yes" response to any mental health screening question on the reproductive health history or pregnancy testing/counseling service visit will initiate a more comprehensive mental health/depression screening. Staff will provide the "Patient Health Questionnaire-9 (PHQ-9) form to the client to complete. Staff will score the PHQ-9 form and enter the PHQ-9 screening data into the EHR. The Advanced Practice provider must be notified of any affirmative "yes" response to mental health screening and PHQ-9 score.
- Clients with a score of 4 or less and the answer to question #9 is zero require no intervention. Clients with a score of 5-9 and the answer to question #9 is zero will receive information regarding local resources for counseling and support. The Advanced Practice provider is notified of clients with PHQ-9 scores of 10 or >, or the answer to Question #9 is 1 or > or the client's answer to the question "if you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?" is "somewhat difficult", "very

difficult", or "extremely difficult", with recommendations for follow-up/treatment based on client PHQ-9 score, assessment and history. A follow-up appointment may be scheduled, referral made to **Vaya Mental Health Services** and/or immediate initiation of mental health crisis services (emergent) for a client determined to be a danger to self or others. (ST-FP-11) **(R)**

- If Postpartum, client must be screened with a validated assessment tool such as the **GAD-7 and EPDS assessment tool for depression and anxiety.**

f. Sexually transmitted diseases including HBV, HCV if indicated and HIV **(R)**

g. Immunization assessment including Rubella status – The Division of Public Health Services staff will screen all Family Planning clients for immunization status in accordance with recommendations of CDC's Advisory Committee on Immunization Practices (ACIP). Clients will be counseled regarding recommended age- appropriate vaccinations and referred to their designated primary care physician (PCP) or the Division of Public Health Services immunization clinic for these vaccines. **(R)**

h. Screening for Intimate Partner Violence and provide referral as indicated. **(R)**

i. Review of Systems – See current Family Planning Reproductive Health Flow Sheet Electronic Medical Record Form. **(R)**

j. Assessment of Reproductive Life Plan **(R)**

k. Assessment of unprotected intercourse in the previous five days. Provide education on Emergency Contraception availability for female clients and/or how a male client may obtain for a female partner. **(R)**

l. Environmental exposures/hazards. **(R)**

m. If postpartum advised to delay future pregnancy for **a minimum of 6 months and are counseled on the risk verses benefits of a repeat pregnancy sooner than 18 months. (R)**

3. **Problem Focused Office Visits:** Other Office Visits (excluding routine supply visits) **may prompt family planning care including initiation of contraceptive care and** include:

a. Description of chief complaint; **(R)**

b. Problem specific history; **(R)**

c. Evaluation of birth control methods and opportunity to change methods; **(R)**

d. Depression screening (See previous History section for guidelines) as indicated based on previous screening results; **(R)**
e. General update of client/family medical history, social/sexual history, allergies, medications and immunization status; **(R)**
f. Blood pressure as indicated; **(I)**
g. Weight/Height/BMI as clinically indicated; **(I)**
h. Pertinent review of systems; **(R)**
i. Problem focused examination and labs as indicated; **(R)**
j. Education and counseling as indicated **(R)**

4. The following laboratory tests will be obtained on all initial and **annual** preventive appointment visits and other office visits as indicated by history, physical, method, and/or previous lab tests.

a. Hemoglobin (I)
b. Urinalysis (I)
c. Pap smear (I) beginning at age 21 **in accordance with ASCCP guidelines**
d. Chlamydia (I) *
e. Gonorrhea (I) *

* Any client who tests positive for either Chlamydia or Gonorrhea must be retested at three months after treatment per current CDC/STD Treatment Guidelines.

f. Syphilis serology (I)
g. HIV testing (I)
h. Wet mount (I)
i. Pregnancy test (I)
j. Diabetes testing (I) *

* Diabetes/prediabetes screening for undiagnosed non-pregnant adults aged 35-70 years who are overweight or obese. The Advanced Practice provider should offer or refer clients with prediabetes to effective preventive interventions.

Diabetes Screening Parameters:

1. Fasting finger-stick blood glucose measurement may be obtained on day of service when the client reports fasting status; or

   (Fasting is defined as no consumption of food or drink in the previous 8 hours, only water or black coffee may be consumed.)

2. Recommendation of return Family Planning lab only visit for fasting finger-stick blood glucose measurement for clients who are non-fasting on day of service; or

3. Serum HgbA1C measurement as recommended by the Advanced Practice provider.

Clients needing recommended Hepatitis C screening (recommended for persons at high risk for infection for Hepatitis C, and one-time screening for HCV infections for all persons 18-79 years of age) will be referred to Adult Primary Care, client's established Primary Care Provider, or to other available community resources as indicated.

LABS:

1. Gonorrhea *(Required if ≤25 years of age and as indicated for those 26 and older and have symptoms, sex partner referral, or high-risk history (such as new partner or multiple partners) per CDC guidelines and/or with IUD insertion if required per CDC's STD Screening Guidelines (U.S. Selected Practice Recommendations [SPR], **2021**).

2. Chlamydia *(Required if ≤25 years of age and as indicated for those 26 and older and have symptoms, sex partner referral, or high-risk history (such as new partner or multiple partners) per CDC guidelines and/or with IUD insertion if required per CDC's STD Screening Guidelines(U.S. Selected Practice Recommendations [SPR], **2021**).

3. Syphilis serology (I) (CDC recommends screening MSM, those living with HIV, commercial sex workers, persons who exchange sex for drugs, those in adult correctional facilities and those living in communities with high prevalence).

4. HIV Testing (I) (CDC recommends all clients aged **15-65** be screened annually and all persons likely to be at high risk for HIV be rescreened at least annually: IDU and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, MSM or heterosexual person who themselves or sex partners have had more than one sex partner since their most recent HIV test).

(R) Required to recommend and offer
(I) Required when indicated by age, history, physical findings, method, previous lab tests, and/or ACOG/ACS/USPSTF/ASCCP/ASCP/SPR/QFP; if indicated and documentation does not demonstrate that the screening/test/service was offered, the client record will be held out of compliance **and if declined, this must be documented in the record**.

Note: If a client chooses to decline a service, this must be documented in the record. Return appointment does not include routine supply appointment.

5. Physical Assessment:

   All clients will receive Initial and**/or Annual** Preventive appointment visits which consist of:

   a. Weight/Height/Body Mass Index (BMI) (R)
   b. Temperature (I)
   c. Blood pressure evaluation (R) **(Clients may decline any physical assessment components and still receive contraception, with exception of blood pressure measurement for combined hormonal contraception)**
   d. Thyroid (I)
   e. Heart/Lungs/Extremities (I)
   f. Breast examination (I)
      Routine, clinical breast examinations begin **by** age 25 **and will be completed every 1-3 years based on age, history, risk and shared decision making between the client and Advanced Practice Provider (APP) in accordance with ACOG guidelines.**
   g. Abdomen (I)
   h. Pelvic examination (females) (I)
   i. Genitals (males) (I)
   j. Pap test (I)

      The Division of Public Health Services Family Planning Program follows the current American Society for Colposcopy and Cervical Pathology (ASCCP) guidelines for PAP screening and management.

   k. Rectum (I)
   l. Colorectal cancer screening (I)

(R) Required to recommend and offer
(I) Required when indicated by age, history, physical findings, method, previous lab tests, and/or ACOG/ACS/USPSTF/ASCCP/ASCP/SPR/QFP; if indicated and documentation does not demonstrate that the screening/test/service was offered, the client record will be held out of compliance **and if declined, this must be documented in the record**.

6. Routine contraceptive injection supply visit:

   Clinic visit for women enrolled in Family Planning clinic returning for routine Depo-Provera injection every 11-13 weeks for IM route or every 12-14 weeks for SQ route.

   - General update of client/family medical history, with **review/** up-date of allergies and medications.
   - BP, Height/Weight/BMI calculation (client may decline and still receive Depo-Provera contraceptive method).

- Evaluation of method, satisfaction with chosen method, opportunity to change method, administration of method as indicated/desired by the client.

7. Method Specific Informed Consent:

These activities must be completed prior to or at the time of receiving a contraceptive method. Written informed consent, specific to the client's chosen contraceptive method, must be signed before a prescription/non-prescription contraceptive method is provided.

a. Counseling and information such as effectiveness, potential side effects, complications, discontinuation issues and dangers of all contraceptive methods including benefits and risks of each method is provided. Clients are given clear and easy to understand educational materials on all methods.
b. Any individual risk to a contraceptive method should be identified on the method-specific consent form or within the clinical documentation.
c. A consent form written in a language understood by the client or translated and witnessed by an interpreter. This form must be part of the client's medical record.
d. Consent forms are updated and resigned with any change in contraceptive method.
e. Information about emergency and after hour services is provided. Warning signs for rare but serious adverse events and what to do if the client experiences a warning sign (including emergency 24 hour number, where to seek emergency services outside of the Division of Public Health's operation hours.)
f. Information about availability of emergency contraceptives.
g. Deferment of physical exam for clients requesting contraceptive services will be documented in the client record stating the reason for deferment. The client will be counseled about the possible health risks associated with declining or delaying preventive screening tests or procedures. Clients may decline any Family Planning services/testing and still receive any type of contraception, except for combined hormonal contraception. Blood pressure evaluation is required for combined hormonal contraception. Agency must obtain written documentation of declination.

H. <u>Post Counseling after Female Physicals</u>:

These activities should be completed after the examination has been completed and a method of birth control has been chosen and prescribed.

1. Instruction in the use of chosen and prescribed method of contraception (both oral and written instructions).

2. Interpretation of clinical findings – normal and abnormal findings.

3. Instructions are given for return appointments. Return office visits are individualized based on the client's needs for education, counseling, and ongoing clinical care.

4. Instructions are given concerning availability of follow-up services for nutritional or medical problems.

5. Public Health Nurse or Advanced Practice provider completes Family Planning Encounter Form and ESB (electronic super bill).

6. Family Planning postpartum clients are counseled on reproductive life planning concerning the importance to delay pregnancy for at least **6 months postpartum and are counseled on the risks and benefits of a repeat pregnancy sooner than**18 months after delivery. The counseling will help the client to select a method of contraception to prevent pregnancy and/or promote healthy birth spacing.

7. Clients who have high-risk behavior for HIV/STD are counseled concerning the importance of prevention. Condoms are dispensed, with instructions for correct use, if client agrees to use for preventive measures.

8. Referrals and follow-up for abnormal clinical findings will be documented within the client medical record. Clients may be referred to outside health care providers for additional services or for services that are determined to be beyond the scope of available services at the Division of Public Health Services.

   When a referral is made, the following issues must be addressed:

   - The Division of Public Health Services will assure the provision of pertinent client information to the referral provider.
   - Client's consent to such arrangements is obtained, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality;
   - Advise client on their responsibility in complying with the referral; and
   - Counsel client on the importance of such referral and the agreed upon method of follow-up.

Efforts may be made to aid the client in identifying potential resources for reimbursement of the referral provider. However, the Division of Public Health Services is not responsible for this cost. The Division of Public Health Services shall maintain a current list of health care providers, local health and human services departments, hospitals, voluntary agencies, and health services projects supported by other Federal programs to be used for referral purposes. Whenever possible, clients should be given a choice of providers from which to select. **When a referral is made to meet identified social services needs, this will be documented in the client's electronic medical record.**

9. Clients without a high school diploma will be counseled about the benefits of completing high school or obtaining a G.E.D.

10. Counseling and treatment for diagnosed sexually transmitted diseases as indicated.

I. Sterilization - Female:

1. Family Planning clients not covered by private insurance, Medicaid or **Family Planning** Medicaid may be eligible for these services and are referred to the Division of Social Services for ACA insurance coverage, Medicaid or Family Planning Medicaid application and services eligibility determination for sterilization if this is the client's chosen reproductive life plan. Clients requesting sterilization are counseled by clinical staff on risk and benefits of sterilization as a permanent option of birth control.

   When no Federal, state or county funding for sterilization is available, the Division of Public Health Services Family Planning program will be unable to offer this service. The Division of Public Health Services will submit annually, by **June 30, 2024**, a letter to the WHB requesting a waiver from the annual reporting required for sterilization services stating the Division of Public Health neither performs nor arranges for sterilization services funded with federal funds. **The waiver letter request should be submitted via Smartsheet @ https://app.smartsheet.com/b/publish?EQBCT=82018408e7b44ef9b44e113b6e536ffb.**

2. Family Planning female clients who have private insurance or Medicaid are referred to M.D. of choice. The clients should sign a Terms and Conditions for Our Clients/Acknowledgement for Receipt of Notice of Privacy Practices form and a copy of her last physical, Pap smear, and any other pertinent information is provided to the M.D. If the M.D. is out of the county the medical information may be mailed/faxed with safeguard to maintain the client's

confidentiality. The client should have had a physical within the last year.

3. Family Planning clients who become pregnant and request sterilization post-delivery usually consult with and choose sterilization from the M.D. who performed their delivery.

J. Vasectomy

1. Vasectomies are arranged/performed through the Regional Vasectomy Program. The Division of Public Health does not "perform"' nor "arrange for" vasectomies, but does provide counseling and referral to the Regional Vasectomy Program.

2. Referral Procedure

a. Clinical appointments are required and are made at the convenience of the client and counseling staff to ensure adequate time to complete the counseling.
Client is counseled on risk and benefits of vasectomy with informed consent obtained prior to the referral.

b. The counseled client signs the sterilization consent form and the information is forwarded to the Regional Vasectomy Program with appointment for vasectomy made through the Regional Vasectomy Program.

c. The Regional Vasectomy Program arranges for the vasectomy procedure and completes the reporting requirements to the WHB as described above.

3. If the Regional Vasectomy Program funds have been exhausted, the client is placed on a waiting list and contacted when funds are available.

4. Client receiving vasectomy assistance are reported to the state by the Regional Vasectomy Program using Form PHS-6044.

K. Infertility Services

1. Criteria for diagnosis of infertility
Infertility is a condition of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.

2. Scope of infertility services

The Division of Public Health Services may provide Level 1 infertility services that will include:

a. Initial infertility interview

b. Education
c. Physical examination
d. Counseling
e. Referral to M.D. of client's choice. Client will be informed that any fees associated with the referral will be the client's financial responsibility.

3. Referral Resources in Rockingham County

Clients may be referred to physician of choice for level 2 and 3 infertility services. Rockingham County referral resources include:

a. UNC Women's Health at Eden, Eden, NC
b. Center for Women's Healthcare @ Family Tree – Reidsville, NC.

L. Education:

1. The client should receive and understand the information she/he needs to make informed decisions and follow treatment plans. This requires careful attention to how information is communicated.

- Educational materials should be clear and easy to understand. (R)
- Information should be delivered in a manner that is culturally and linguistically appropriate. (R)
- The amount of information should be limited and emphasize essential points which focus on knowledge gaps identified during the assessment. (R)
- Whenever possible, natural frequencies and common denominators (i.e., 1 in 100 using an IUC or implant is likely to get pregnant within 1 year, etc.) are used in the education activity. (R)
- Balanced information on risks and benefits of the contraceptive method chosen should be presented and messages framed positively. (R)
- Active client engagement should be encouraged and each visit should be tailored to the client's individual circumstances and needs. (R)

2. Client education **and counseling regarding the following should** be documented in the record **where applicable** and must provide clients with information needed to:

a. Use specific methods of contraception and identify adverse effects (R)**(at initiation of a contraceptive method).**
b. **Reduction of risk transmission of STIs and HIV based on sexual risk assessment. (I)**

c. **Promote daily consumption of multivitamin with folic acid to those who are capable of conceiving (R)**
d. **Provide reproductive life planning counseling (R)**
e. **Review immunization history and inform patient of recommended vaccine per CDC's ACIP Guidelines and offer, as indicated, or refer to other providers/RCDPH immunization clinic. (R)**
f. **Provide preconception counseling (R)**
g. Understand BMI greater than **30** or less than 18.5 is a health risk. (Weight management educational materials to be provided if client requests. (I)
h. **Stop tobacco or Electronic Delivery Systems (ENDS) use implementing the 5A counseling approach. (I)**
i. **Encourage mammograms in accordance with the nationally recognized guidelines RCDPH has chosen to follow and has incorporated into RCDPH policy/procedure/protocol. (I)**
j. **Provide achieving pregnancy counseling (I)**
k. **Provide basic infertility counseling (I)**
l. **Provide GED counseling (I)**

(See Adolescent Services Policy for adolescent-specific counseling FP-5.)

M. Required Client Method Counseling

Method counseling is an individualized dialogue that must be included in the client's medical record. It covers:

1. Results of physical assessment and labs (if performed) (I)
2. **Client centered contraceptive counseling/education provided** (R)
3. Provide emergency contraception counseling **if pregnancy is not desired (I)**
4. How to d/c method selected, information on back-up method (R)
5. Typical use rates for method effectiveness (R)
6. How to use the method consistently and correctly (R)
7. Protection from STDs if non-barrier method chosen (I)
8. Warning signs for rare but serious adverse events and what to do if they experience a warning sign (including emergency 24 hour number, where to seek emergency services outside of hours of operation) (R)

9. When to return for follow-up (planned return schedule) (R)

10. Appropriate referral for additional services as needed (R)

N. Documentation:

1. All clients seen in the Family Planning Program will have appropriate documentation within the client's medical record.

2. Diagnosis, Treatment, Referral and Follow-Up Services - There will be evidence in the clinical record that:

   a. Significant problems were identified, documented, and referrals made as needed;
   b. Significant abnormal clinical and laboratory findings were discussed with the client;
   c. Necessary clinical procedures were performed;
   d. Medications and/or supplies were provided as needed; and
   e. Problems, conditions, and abnormal findings are appropriately followed. Client may be referred to Adult Primary Care for follow-up or to an appropriate outside medical **or social services** provider of client choice.
   f. Coordination of Women's Health clinical services will be made through intra-agency referrals through the various programs within the Division of Public Health Services when these available services meet the client's needs.

O. Confidentiality:

Confidentiality will be maintained on all Family Planning clients in the following manner:

1. Confidentiality, as well as privacy, is maintained during clinical appointments. Clinical staff assure conversations occur behind closed doors in private rooms, exam rooms are equipped with privacy screens and disposable gowns/drapes are used, etc., to assure client privacy.

2. On initial interview in Family Planning Clinic clients are informed that automated appointment reminders are provided to clients by email, SMS text messaging, and voice mail as permitted by the client to remind them of physical appointments unless the client requests no notification.

3. When indicated, if the client has answering service per telephone, a message may be left if telephone calls are permitted and the client has not requested confidential services. Messages will be limited to request for return call to the Family Planning Clinic staff.

4. For those clients who request no automated messaging**,** mail or phone calls, the client's address and/or phone number is entered as confidential in the computer registration personal data fields.

5. Confidential client charts are flagged as confidential by use of the red color flag. Individual client encounters are also designated as confidential.

   No Telephone calls/No mail to home/No Automated Messaging can be designated as well.

6. No information obtained by the Agency staff will be disclosed without the individual's written consent, except as required by law or as necessary to provide services to the individual, with appropriate safeguards to the individual.

7. Information will be disclosed only in summary, statistical, or other form that does not identify the individual.

8. Adolescents requesting confidential services must be assured that Family Planning services are confidential and, if follow up is necessary as a result of any laboratory or examination findings, every attempt will be made to assure the privacy of the individual. **Adolescents are counseled about limitations to confidentiality. (See FP-5 Adolescent Services Policy.)**

9. A confidentiality assurance statement is located in each Family Planning client's general consent for services and signed by the client.

Note: For additional information related to confidentiality within the Family Planning Program, please refer to the Division of Public Health Services, Health Insurance Portability and Accountability Act Policy Manual.

P. Conflict of Interest:

No employee, consultant, or member of the governing board may use their position for purposes of private gain for themselves or others (see QI-9 policy Conflict of Interest).

Q. Staff Follow-up of Abnormal Tests and Findings:

1. Clients seen in Family Planning program are advised of the Division of Public Health Services practice of notification of abnormal test results only. Clients are given guidance on expected time period for receipt of all lab test results and to expect NO notification if all test results are normal/negative, including PAP screening test results. Advanced Practice providers review laboratory results and determine management for individual clients. Clients are advised

that they will be contacted by Family Planning staff (communication may be by the staff nurse as directed or by the Advanced Practice provider) with any abnormal test results requiring follow-up or treatment. Due to the sensitive nature of screening laboratory test results, clients are requested to provide a preferred, reliable method of contact to receive any abnormal lab results. Contact information is reviewed with the client during the clinical visit.

2. Family Planning staff will attempt contact with the client for abnormal laboratory test notification by the client's preferred contact method.

3. These contact attempts may be made per telephone or letter in accordance with the client's stated preference for contact and confidentiality. If client accepts telephone calls and mail, two attempts will be made by telephone. If no response to telephone calls, a letter will be mailed to the client. Client follow-up will be closed if no response to the third contact attempt.

   If the client accepts mail but no telephone calls, three attempts will be made by mail. Client follow-up will be closed if no response to three letters. If the client accepts no telephone calls or mail and the abnormal test results represent sexually transmitted infection, a no return address postcard (clients instructed on the postcard meaning at the clinical visit) will be mailed to the client. If no response to the postcard, the client information will be referred to the Communicable disease nurse or regional DIS.

   If the abnormal test result represents PAP result requiring follow-up or high grade abnormal PAP smear, every attempt will be made to contact the client either by telephone or letter. Three attempts will be made to contact the client with abnormal PAP test requiring follow-up. A final attempt to contact the client by mail will be a certified letter notification. During the clinical appointment the client is told if Pap smear is normal she will not get any type of notification, but if there are any findings that need to be discussed with her, she will receive notification per mail. Clients are requested to provide a method of contact to receive PAP test results requiring follow-up.

   Abnormal test results not determined to be acutely detrimental to health may be provided to the client at the next clinical visit, per Advanced Practice provider recommendation, when the client accepts no telephone calls or mail.

   Designated Family Planning staff will track and follow-up outside referrals related to gynecological problems, such as needed ultrasound, or for breast health problems, such as need for

diagnostic mammogram or for procedure referrals such as LEEP, CKC as recommended by consulting physician after colposcopy, or for any other referral as requested by the Advanced Practice provider.

For clients requesting normal/abnormal test results (except positive HIV), results may be given over the telephone upon verification of the client's identity. The client must provide at least two client specific identifiers other than their name, i.e. date of birth and social security number.

Clients requesting a copy of any test result must present to the clinic in person, provide proper identification and sign a release of information to receive the test results and pay the nominal required fee for paper copies.

R. Management and Follow-up of Pap Test Results Protocols:

The Division of Public Health Services Family Planning Program follows the current guidelines for Pap screening and management as based on nationally recognized standards of the American Society for Colposcopy and Cervical Pathology (ASCCP) https://www.asccp.org.

- **All Family Planning PAP test results are reviewed by the APP with schedule for retreating, follow up and/or for recommendations due to abnormalities documented in the client record.**
- **The APP or designated FP RN staff notify the client of PAP test results per the client's preferred method of notification.**
- **The APP assigns a referral for management of further testing/ procedure to designated FP RN staff as indicated.**
- **The APP forwards charts requiring routine PAP retesting to designated clerical staff for letter notification when next recommended testing is due.**

S. Missed Appointments:

Family Planning clients who designate no restrictions for receiving telephone calls or mail will be notified of missed appointments by telephone or mail as time and staffing permits:

1. Clients not requesting confidential services who may receive telephone calls will be called to advise them of the missed appointment as time and staffing permits. (A message may be left if telephone calls are permitted.)

2. Clients not requesting confidential services who decline telephone calls and permit mail will be sent a letter (as time and staffing permits) stating, "You have missed your Family Planning

appointment at the Rockingham County Department of Health and Human Services Division of Public Health Services. Please contact the Division of Public Health Services to reschedule your appointment." Clients who designate no telephone calls or mail will not be notified of missed appointments.

3. Family Planning staff will document the results of any attempt to notify the client of a missed appointment in the client's medical record as time and staffing permits.

T. Improving Organizational Performance:

1. State and local reports and statistics are reviewed at least annually to determine if the needs of the community are being met and changes made if indicated. The Division of Public Health will annually create a Community Engagement Plan, Education and Service Promotion Plan and Quality Improvement Project (CEQ) per Title X requirements. This plan provides community partners opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served; and by persons in the community knowledgeable about the community's needs for family planning services.

2. Family Planning Program chart audits will be completed quarterly. These reviews will include the Advanced Practice provider and all Family Planning staff.

   a. Audits will be completed quarterly.
   b. The purpose of the chart audit will be to:
      - Ensure that the level of medical care specified by the contract addendum, Family Planning Policies, procedures, and protocols of the specified programs are being met.
      - Discuss problems in clinic and Family Planning Program and make recommendations to correct deficiencies found, and other improvements.
   c. The chart selection will be random charts from Family Planning program and quarter in review. The state audit forms will be used.
   m. The results of the audit will be tabulated and recorded in minutes. Information discussed within the report will have the client MR number, rather than any other identifying information. A corrective action plan (CAP) will be completed by the PHN FP Supervisor based on the audit results/any problems identified.

e. All members of the program team will be informed of the results of the audit as well as the strengths and weaknesses identified and summarized within the corrective plan of action.

U. Rockingham County DHHS-Division of Public Health Clinical services will distribute and monitor electronic client satisfaction surveys.

1. Client Satisfaction Surveys are electronically distributed, per utilization of the Electronic Health Record, monthly for all DHHS clinical programs including Family Planning Program.

2. Monthly survey results are analyzed by designated staff and a report of the findings will be generated and distributed to staff. Areas for improvement will be addressed to ensure customer satisfaction by staff utilization of knowledge obtained from surveys.

3. Family Planning client survey results provide input regarding client levels of satisfaction with the clinical services received. Survey results are evaluated to aid in determination in service adjustment as indicated.

4. The results are also disseminated to the Board of Health and Human Services.

IV. APPLICABLE LAWS, RULES AND REFERENCES:

a. Program Requirements for Title X Funded Family Planning Projects https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates

b. Providing Quality Family Planning Services https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf

c. U.S. Medical Eligibility Criteria For Contraceptive Use, 2016 **and 2020 partial update** **https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf and https://www.cdc.gov/mmwr/volumes/69/wr/mm6914a3.htm?s_cid=mm6914a3_w**

d. U.S. Selected Practice Recommendations For Contraceptive Use, 2016 https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504a1.htm.pdf

e. **Women's, Infant and Community Wellness Section website https://wicws.dph.ncdhhs.gov/provpart/index.htm**

Rev/di

Patient Label

ROCKINGHAM COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Public Health Services

Declination of Offered Services

I, _____, have been informed of services recommended by the Rockingham County Department of Health and Human Services staff to diagnose and/or treat symptoms I am having. I understand services may include the following:

[ ] Colposcopy

[ ] Ultrasound for: _____

[ ] Pap smear

[ ] Mammogram

[ ] Referral to another medical professional: _____

[ ] Blood work for: _____

[ ] Other: _____

I completely understand the verbal and/or printed information provided by the Rockingham County Department of Health and Human Services staff. I understand the potential consequences to my health and well-being if I decline the services offered. I understand that some of the services offered would be my financial responsibility. I also understand that I can request these services at a later date.

Signature: _____

Date: _____/_____/_____

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PREGNANCY DIAGNOSIS AND COUNSELING

DATE DEVELOPED: **4/2015**
REVIEWED: **6/16; 10/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/16; 10/16; 6/17; 6/18; 6/19; 6/20; 6/22; 6/23; 6/24**

I. POLICY:

The Division of Public Health Services' Family Planning Program provides pregnancy testing to all clients requesting this service. These clients are enrolled in Family Planning Services and charged according to Family Planning Program eligibility guidelines. These clients will be assessed with findings documented solely pertaining to determining pregnancy status.

II. PURPOSE:

The Division of Public Health Services will provide pregnancy testing for all female clients in need of this service to assure early access to prenatal care to improve pregnancy outcomes.

III. GUIDELINES:

A. Clients requesting pregnancy testing who have a negative test and who do not desire to be pregnant, are counseled on the value of making a reproductive life plan (do you have any children now?, do you want to have more children?, and how many more children do you want to have and when?), the availability of family planning services and provided with information/counseling on all methods of birth control requested.

B. Minors under 18 years of age will be counseled about the importance of discussing birth control needs with family members/ a trusted adult and about expectations to confidentiality (NC mandatory reporting of abuse/neglect rules).

C. For the client who desires to be pregnant, and has a negative test – this person is counseled on pre-conception health-benefits of proper nutrition, folic acid, avoidance of drugs, alcohol, vaping products or tobacco products and foods to avoid during pregnancy, exercise and/or a healthy weight program. Family Planning staff members provide current Media Review approved educational resources including:

- Am I Ready to Be a Mom? - English/Spanish
- Birth Control, Talking with your Parents - English
- Are You Ready? Sex and Your Future - English/Spanish
- Take Care of Yourself, Your Body Will Thank You for It – English

- **You Deserve To Be Your Very Best! Make Good Health A Habit for LIFE! Start Today – English**
- **¡Usted Merece ser la major versión de sí misma! ¡Haga Que la Buena salud sea un hábito para toda LA VIDA! Empiece hoy - Spanish**
- RHNTC Birth Control Method Options - English/Spanish
- Family Planning Methods – English/Spanish
- Birth Control Facts – English/Spanish
- There Are More Birth Control Methods Than You Think – English/Spanish
- Healthy Habits for Life -English/Spanish
- Weight and Women - English/Spanish
- Living Smoke Free for You and Your Baby - English
- The Decision Is Yours…(Tobacco risks) – English
- E-Cigarettes & Vaping…Information for Women & Their Families – English/Spanish
- CDC's Response to Zika: The Basics of The Virus and How to Protect Against It – English/Spanish
- CDC's Response to Zika: Thinking About Having a Baby? Warning: Zika is Linked to Birth Defects – English/Spanish

Refer to Infertility protocol for the client who meets criteria for diagnosis of infertility (See Family Planning Policy FP-1).

D. Family Planning **staff, including registered** nurses **must offer** pregnant women **the opportunity to be provided information and counseling regarding the following pregnancy options, unless the patient indicates that the individual does** not want information on one or more options:

- Pregnancy termination;
- Prenatal care and delivery, and
- Infant care, foster care, or adoption.

Clients requesting further information/counseling on any of these pregnancy options will receive neutral, factual, non-directive counseling by the **registered** nurse or Advanced Practice Provider (APP) **on each of the options except with respect to any options about which the pregnant patient indicates they do not wish to receive such information and counseling**. Family Planning staff will provide a referral, upon request, for any pregnancy option the client requests as well as a list of resources designating specific services available at each facility. All clients who express an interest in prenatal care will be offered a referral for prenatal care and this referral will be documented in the medical record.

1. Prenatal care and delivery: The Division of Public Health does not provide a prenatal clinic; however, prenatal services are assured. All clients with positive pregnancy tests who express an interest in receiving prenatal care will receive a referral for prenatal care. If

LMP is uncertain, the APP may perform a limited examination to assess fundal height or Doppler fetal heart tones to assist in determination of gestational age to aid in appropriate options.

2. Infant care, foster care or adoption: Adoption information and referral is provided for the client who feels she is unable to provide for her baby and desires referral. The client is assured that going to adoption counseling does not mean that she may not later change her decision.

3. Pregnancy termination: Information is provided for the client who does not desire to continue the pregnancy and verification of the positive pregnancy test is given to the client. **The referral process should include providing the patient with a provider list that includes the name, address, telephone number, what services are offered, and other relevant factual information. Family Planning staff may not take further action (making an appointment, providing transportation) to secure pregnancy termination services for the patient. Where a referral to another provider who might perform an abortion is medically indicated because of the patient's condition (such as where the woman's life would be endangered by continuing the pregnancy or the condition of the fetus), such a referral is not prohibited and is required.**

4. A list of licensed, qualified, comprehensive primary health care providers including local prenatal provider resources is provided at the client's request. Clients will be assessed regarding a primary care provider. Those determined to have no primary care will be offered a referral and given local provider resource information with this information documented in the medical record.

E. For a positive pregnancy test on the client who desires the pregnancy and does not have Medicaid or medical insurance covering pregnancy, presumptive eligibility for Medicaid is initiated for all clients. Presumptive eligibility for Medicaid may also be completed for clients who have private health insurance coverage; these clients may also be eligible for pregnancy Medicaid. The insured client is referred to private M.D. of choice for prenatal care. Referrals for clients without insurance are made to prenatal providers with whom the Division of Public Health Services has a contract to assure that these women have access to prenatal care. Clients with positive pregnancy tests will be followed up by Division of Health Services staff to assure client has access to a health care provider. Physical assessment and pelvic examination are not done routinely at time of positive pregnancy test; however, the client is counseled on the importance of receiving a physical assessment as soon as possible, preferably within 15

days. Clients suspected of an ectopic pregnancy will be referred for immediate diagnosis and treatment.

Contracting providers assuring prenatal care:

- UNC Women's Healthcare at Eden – Eden, NC
- Center for Women's Healthcare at Family Tree – Reidsville, NC

F. All clients with a positive pregnancy test are educated on the warning signs of an ectopic pregnancy:

- Unexplained vaginal bleeding
- Abdominal pain
- Dizziness
- Syncope
- Where to seek care should client experience any of the symptoms before the prenatal appointment.

G. All clients with positive pregnancy tests are provided information about the importance of avoiding over-the-counter medications; to avoid alcohol, street drugs, x-rays, foods to avoid during pregnancy and on smoking risks with tobacco cessation resources provided as indicated. Clients reporting vaping are provided with information on detrimental effects of vaping. Clients are advised to be vaccinated for seasonal flu, when available, with referral to immunization clinic at the Division of Public Health Services if the client desires this service. Referrals are made to WIC Program for nutritional counseling and the Care Management for High Risk Pregnancies Program (CMHRP) unless the client declines these referrals. Clients are also provided information on available community based education resources regarding pregnancy/and or parenting. Family Planning staff members utilize current Media Review approved education resources when providing counseling, including:

- Healthy Mom, Healthy Baby-Your Pregnancy Guide - English/Spanish
- Family Planning Methods - English/Spanish
- Birth Control Facts - English/Spanish
- If You Smoke and Are Pregnant - English
- Living Smoke Free for You and Your Baby – English
- E-Cigarettes & Vaping: Information for Women & Their Families – English/Spanish
- CDC's Response to Zika, Pregnant? Warning: Zika is linked to Birth Defects – English/Spanish

Clients reporting health conditions with potential adverse pregnancy outcomes will be counseled by the APP. Clients' self-reported history of chronic health conditions, with current medication treatment of the condition, and/or current presentation of acute symptoms/ risk factors

requiring immediate/expedited prenatal provider evaluation will receive counseling and/or care recommendations by the APP. Chronic/other health conditions may include but are not limited to:

- Chronic Hypertension (medication treatment of Hypertension)
- Diabetes Mellitus
- History of high risk pregnancy
- History of tubal pregnancy
- Intrauterine device

H. All clients with a positive pregnancy test will be assessed for varicella immunity. Pregnant women with no immunity will be given the information sheet "Preventing Chickenpox in Pregnant Women" – English/Spanish.

I. For clients with active Medicaid or private insurance, a Prenatal Plus vitamin prescription may be called to the client's choice of pharmacy by the Family Planning RN per Medical Director standing order; OR the prescription may be transmitted electronically to the client's choice of pharmacy by the APP. Un-insured/under-insured Family Planning client prenatal vitamin prescriptions are transmitted to/filled at the RCDHHS-Public Health Pharmacy. (See ST-FP-2)

J. All pregnant clients are encouraged to receive a postpartum check-up with their obstetrical provider. Clients who do not follow-up with their obstetrical provider for their postpartum check-ups may be seen at the Division of Public Health Services Family Planning clinic. Clients seen for a postpartum check-up at the Division of Public Health Services Family Planning clinic will be assessed for their physical health, initiation of contraception, and assessed for counseling/education needs related to parenting, breast feeding, infant care, and family adjustment. Clients seen up to 12 weeks postpartum will receive depression screening and referral for services as indicated. They will be screened with the 5Ps tool and referred for services as indicated. They will be counseled on reproductive life planning to include plans for future childbearing and to promote healthy birth spacing (**delay future pregnancy for a minimum of 6 months and counseled on risks verses benefits of a repeat pregnancy sooner than 8 months**). If a client had a diagnosis of gestational diabetes, follow-up testing will be performed at the postpartum clinic visit. Clients can be referred to a primary care provider if indicated for other problems/conditions.

K. Follow-up of clients with positive pregnancy tests will be completed by designated staff per telephone call to the client's preferred provider to determine if prenatal appointment was kept. If the prenatal appointment is missed without rescheduling and the client is enrolled in the CMHRP

Program, then the missed appointment is referred to the CMHRP Program assigned to this client.

If client is not enrolled in the CMHRP Program, Family Planning staff will attempt contact of the client by telephone or letter to follow-up on the missed appointment and assist with rescheduling.

Three attempts will be made to contact the client, based on the client's chosen allowable method(s) of contact to follow-up on missed appointments. If the client's method of contact permits the client to receive mail, the final attempt will be via a mailed letter. If there is no response, clients who miss 2 initial prenatal appointments without rescheduling may be referred to CMHRP for follow-up even if not enrolled in the CMHRP Program. This follow-up provides continuity of access to prenatal health care.

L. If a pregnant client presents to the Family Planning/STD Program clinic with symptoms of an STD, screening examination is provided by the APP or the client is referred to her prenatal provider.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: INTRAUTERINE DEVICES (IUDs) PROTOCOLS
Manufacturer Prescribing Information; UpToDate®

DATE DEVELOPED: 3/01
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24

I. POLICY:

Intrauterine Devices (IUDs) will be inserted and removed only by a trained Advanced Practice Provider (APP). IUDs will be made available, based on funding, to eligible Family Planning clients, including adolescents, requesting this method of contraception unless medically contraindicated. The Division of Public Health Services strives to provide long acting reversible contraceptives (LARCs) to help reduce unintended pregnancies and improve selected health practices among low-income families. By decreasing the number of unplanned pregnancies and the poor health outcomes associated with these pregnancies, the Division of Public Health is also reducing infant mortality and morbidity.

II. PURPOSE:

Intrauterine Devices (IUDs) offer long-term reversible contraception options (LARCs) for females choosing this type of birth control method. The Division of Public Health Services strives to offer provision of safe and effective IUD insertion, removal and surveillance to eligible Family Planning clients. **A single IUD is effective pregnancy prevention with < 1 pregnancy per 100 women in a year (> 99% efficacy) for three to ten years depending upon the intrauterine device chosen.**

III. GUIDELINES:

A. General

An IUD is a sterile foreign body placed in the uterus to prevent pregnancy. Different types of IUDs use varying mechanisms of action to prevent pregnancy including: interference with sperm transport or fertilization and prevention of implantation (Paragard) and thickening of cervical mucous, alteration in endometrium, inhibition of sperm survival (LNg IUD). However, the exact mechanisms of action are not completely understood.

Types of IUDs:

- Mirena IUD-52 mg Levonorgestrel (8 year effectiveness)
- Kyleena IUD-19.5 mg Levonorgestrel (5 year effectiveness)
- Skyla IUD-13.5 mg Levonorgestrel (3 year effectiveness)

- Paragard Copper IUD- non hormonal (10 year effectiveness)
- Liletta 52 mg Levonorgestrel (**8 year** effectiveness)

B. Contraindications:

1. Absolute Contraindications (any type of IUD):

   a. **Pregnancy**
   b. Severe distortion of the uterine cavity (such as by fibroids or anatomic anomalies) that precludes IUD insertion.
   c. Untreated acute cervicitis or vaginitis, or other lower genital tract infection until infection is controlled.
   d. Active genital actinomycoses
   e. Known or suspected uterine or cervical malignancy
   f. Previous IUD that has not been removed
   g. Postpartum endometritis or infected abortion in the past 3 months
   h. Acute pelvic inflammatory disease (PID)
   i. Unexplained abnormal uterine bleeding

   Absolute contraindications to use of the Cu T380A IUD (Paragard):

   a. Wilson's disease
   b. Known copper allergy

   Absolute contraindications to use of the LNg IUD (Mirena, Kyleena, Skyla, Liletta):

   a. Known allergy or hypersensitivity to Levonorgestrel or other components of the IUD
   b. Acute liver disease or liver tumor
   c. Known or suspected carcinoma of the breast, or other progestin-sensitive cancer current or in the past
   d. **LNg IUD can not be used for emergency contraception**

2. Relative Contraindications:

   a. Risk factors for STDs (non-monogamous relationship, history of STDs)
   b. History of a previous IUD problem (perforation, significant pain)
   c. Past history of severe vasovagal reactivity

   Relative contraindications for the Cu T 380A IUD only:

   Current anemia or a history of menorrhagia-associated anemia

   Relative contraindications for the LNg IUD only:

   - History of progestin intolerance

C. Insertion:

Supplies Needed - Speculum, betadine or alternative antiseptic, gloves (sterile gloves for Paragard), Monsel's (Ferric Sulfate Solution) as needed, large swabs, tenaculum, uterine sound, long curved scissors, appropriate IUD, silver nitrate as needed.

1. Pre-Procedure:

   a. Ideally a woman is scheduled for an appointment for insertion within 7 days of onset of menses. However, the IUD may be inserted at any time during the cycle if pregnancy can be excluded.
   b. A urine pregnancy test should be **performed**.
   c. Gonorrhea/Chlamydia testing (prior to insertion and/or collected at time of the IUD insertion) as indicated per history and/or CDC's STD screening guidelines (U.S. Selected Practice Recommendations, 2016).
   d. Appropriate medical and menstrual history should be obtained.
   e. Client should be counseled concerning risk of STDs.
   f. IUD consent form must be reviewed and signed at the time of an IUD consultation and evaluation, after discussion of:

      1) Procedure
      2) Mechanism of the device
      3) Side effects and **possible** complications
      4) Relationship to woman's needs

2. Insertion technique:

   a. Bimanual examination should be performed to determine uterine position and size.
   b. Insert speculum.
   c. Cleanse the vagina, cervix, and endocervical canal with betadine solution or alternative antiseptic.
   d. Use tenaculum to straighten uterine body and cervical canal.
   e. Measure uterine cavity with uterine sound.
   f. Insert specific IUD as instructed by manufacturer.
   g. Spasm of the internal cervical os may occur; it is usually relieved by simply waiting.
   h. After insertion, observe the client for weakness, pallor, diaphoresis, bradycardia or tachycardia, hypotension and syncope, which may occur.
   i. If client has mild cramping, the following may be recommended:

      1) Acetaminophen analgesic 650 mg every 4 hours, or

2) A prostaglandin inhibitor (NSAID) such as Motrin® 600-800 mg PO TID.
3) Apply heat to abdomen.

j. Explain to client that the Paragard IUD is effective immediately. If a woman has not, cannot or chooses not to overlap contraceptive methods before insertion of progestin-containing IUD and it is inserted more than 7 days since menstrual bleeding started, the patient should abstain from sex or use a condom for the first 7 days of insertion.
k. Instruct client to check for presence of IUD string post menstruation or after unusual cramping prior to relying on device for continued contraception effect. If not having menses with use of progestin type IUD, check IUD once monthly.
l. Follow-up with appointment in 4-6 weeks for string check**.**
m. Client is provided the Division of Public Health's "Post IUD (intrauterine device) insertion instructions – English/Spanish fact sheet for reference (Media review approved educational resource).

D. Immediate Complications and Possible Interventions:

1. Immediate, severe vasovagal response –

a. Provide emergency care (see Emergency Care Policy NUR-14)
b. Place client in shock position
c. Monitor pulse and blood pressure until stable
d. Administer oxygen as needed
e. Notify emergency services as needed

2. Severe immediate cramping; remove IUD

3. Excessive pain or bleeding **can be** a sign of perforation (fundal); physician consult as needed for management

E. Side Effects (or Later Complications) With Possible Interventions:

1. One or more missed periods with use of Paragard IUD: recommend a urine pregnancy test or serum pregnancy test if indicated. With use of Progestin-containing IUD missed periods is an effect of the device. Perform pregnancy test with symptoms of pregnancy.

2. If pregnancy is confirmed with IUD in place, contact supervising MD.

3. Break-through bleeding related to IUD, possible intervention may include:

- Trial regimen of NSAIDs (Ibuprofen 800 mg PO every 8 eight hours as directed)
- Daily low dose combined oral contraceptive x 1-3 months (if no contraindications)
- Daily Progestin Only Contraceptive Pill (POP) 1-3 months (if no contraindications)
- Megace 40mg TID x 5 days, BID x 5 days, then daily #45 tablets

4. Cramping and pelvic pain –

   a. Rule out ectopic pregnancy

      1) Obtain a pregnancy test as indicated
      2) Consider ultrasound and physician consult

   b. Pain or cramping caused by or associated with

      1) Partial expulsion of IUD
         - Remove IUD
      2) Pelvic inflammatory disease

         - **Promptly evaluate the client**
         - Treat infection
         - **Remove IUD in cases of recurrent endometritis or Pelvic Inflammatory Disease (PID) if acute pelvic infection is severe or is does not respond to treatment.**

5. Expulsion –

   a. Objective findings when the cervix is visualized:

      1) The IUD is seen at the cervical os or in the vagina
      2) The IUD string is lengthened (partial expulsion)
      3) The IUD string is absent (order ultrasound to rule out complete expulsion)
      4) The IUD cannot be located using various methods of probing (order ultrasound to rule out complete expulsion)
      5) The IUD is absent on ultrasound
      6) Consultation with supervising physician as indicated

   b. Removal and reinsertion of IUD:

      1) If partial expulsion occurs, IUD should be removed. IUD may be reinserted immediately if there is no

infection or possibility of pregnancy, or with the next menses.

2) If completely expelled, a new IUD may be reinserted as outlined above.

6. Lost IUD strings –
Referrals for locating IUD include:

a. Exploration of canal with gentle probing; if not found, then
b. Ultrasound
c. **Radiograph**
d. Consultation and referral to supervising M.D. as indicated

7. Difficulty in removing IUD –
The following techniques may help in the removal of IUDs:

a. Remove during menses
b. Employ gentle, steady traction – remove IUD slowly. If unable to remove IUD, refer to MD.
c. If IUD strings are not visible, APP may probe for them in the cervical canal with IUD retriever, narrow forceps, or appropriate instruments. If IUD string(s) is not found, order transvaginal pelvic ultrasound.

8. Uterine perforation (fundal or cervical), embedding of the IUD –

a. Objective findings include:

1) Absence of IUD string
2) Inability to withdraw IUD if string is still present
3) Demonstration of displaced IUD by ultrasound or x-ray

b. If perforation or embedding is suspected and unable to dislodge with gentle traction, refer to MD.

F. Follow-up:

1. Patients should be re-examined and evaluated 4-6 weeks after insertion and once a year thereafter or more frequently if clinically indicated.

2. Papanicolaou test per current Pap screening guidelines (see FP-1 policy) and pelvic examination with removal and/or reinsertion per specific IUD manufacturer's instructions (Skyla® 3 years; Paragard T 380A® 10 years; Mirena® 7 years; Kyleena® **8 years**; Liletta® **8 years**).

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NUVARING

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/16; 6/17; 6/19; 6/20; 6/22

I. POLICY:

The Division of Public Health Services may provide the NuvaRing contraceptive method to Family Planning eligible clients including adolescents. The NuvaRing is indicated for the prevention of pregnancy.

II. PURPOSE:

NuvaRing contraceptive method is prescribed for prevention of pregnancy. It is inserted into the vagina for 3 weeks and releases a continuous low dose of hormone into the body. This type of contraceptive is effective pregnancy prevention with 96-99% effectiveness based on typical use.

III. GUIDELINES:

A. Eligibility:

See Family Planning Policy-1 for Family Planning eligibility determination guidelines.

B. Indication and Usage

One NuvaRing is inserted in the vagina. The ring is to remain in place continuously for three weeks. It is removed for a one-week break, during which a withdrawal bleed usually occurs. A new ring is inserted one week after the last ring was removed.

The user can choose the insertion position that is most comfortable to her, for example, standing with one leg up, squatting, or lying down. The ring is to be compressed and inserted into the vagina. An optional alternative is to insert the ring using the applicator for NuvaRing. The exact position of NuvaRing inside the vagina is not critical for its function. The vaginal ring must be inserted on the appropriate day and left in place for three consecutive weeks. This means that the ring should be removed three weeks later on the same day of the week as it was inserted and at about the same time.

NuvaRing can be removed by hooking the index finger under the forward rim or by grasping the rim between the index and middle finger and pulling it out. The used ring should be discarded in a waste receptacle.

After a one-week break, during which a withdrawal bleed usually occurs, a new ring is inserted on the same day of the week as it was inserted in the previous cycle. The withdrawal bleed usually starts on Day 2-3 after removal of the ring and may not have finished before the next ring is inserted. In order to maintain contraceptive effectiveness, the new ring must be inserted exactly one week after the previous one was removed even if menstrual bleeding has not finished.

Contraceptives that contain both an estrogen and a progestin are called combination hormonal contraceptives. NuvaRing contains a combination of a progestin and estrogen. Most studies on combination contraceptives have used oral contraceptives. NuvaRing may have the same risks that have been found for combination oral contraceptives.

Mechanism: Releases a continuous low dose of ethinyl estradiol, an estrogen, and etonogestrel, a progestin to suppress ovulation (90% to 95% of time). Also causes thickening of cervical mucus, which blocks sperm penetration and entry into the upper reproductive tract. Progestins also makes the endometrium less favorable for implantation.

C. <u>When to Start NuvaRing</u>

The DHHS-Division of Public Health Family Planning Medical Provider may recommend starting NuvaRing immediately (quick-start) or during menses as determined most appropriate after individualized client counseling.

IMPORTANT: The possibility of ovulation and conception prior to the first use of NuvaRing should be considered.

D. <u>Deviations from the Recommended Regimen</u>

To prevent loss of contraceptive efficacy clients should not deviate from the medical provider's recommended use regimen.

Inadvertent removal or expulsion

If NuvaRing has been out of the vagina for less than 3 hours during the three-week use period, it can be rinsed with cool to lukewarm (not hot) water and should be reinserted as soon as possible, at least within three hours. If the ring has been out of the vagina more than three hours, back-up contraception, such as male condoms or spermicide, <u>MUST</u> be used until NuvaRing has been used <u>continuously for seven days</u>.

E. Missed Menstrual Periods

1. If the client has not adhered to the prescribed regimen, (NuvaRing has been out of vagina for more than three hours or the preceding ring-free interval was extended beyond one week) the possibility of pregnancy should be considered at the time of the first missed period and pregnancy test should be done to rule out pregnancy. If pregnancy confirmed NuvaRing use should be discontinued.

2. If the client has adhered to the prescribed regimen and misses two consecutive periods, pregnancy should be ruled out.

F. Vaginal Use

NuvaRing may not be suitable for females with conditions that make the vagina more susceptible to vaginal irritation and ulceration.

Some women are aware of the ring at random times during the 21 days of use or during intercourse. During intercourse some sexual partners may feel NuvaRing in the vagina. However, clinical studies revealed that 90% of couples did not find this to be a problem.

G. Side Effects

Side effects are the same as for combined oral contraceptives. If a patient experiences side effects such as nausea, breast tenderness, intermenstrual bleeding there is a strong possibility those will resolve within the first 3 months of use. If the side effects do not resolve, client may need to consider a different method. If the client has a complaint of severe headaches, the client should be evaluated by a physician extender and a decision made about continuing with method or need for switching to another method. Complaint of chest pains, shortness of breath, leg pain, numbness of extremities, abdominal pain should be reported to the physician extender immediately for evaluation.

The most common side effects reported by NuvaRing users are:

- Tissue irritation inside the vagina or on the cervix
- Headache (including migraine)
- Mood changes (including depression, especially if client has experienced depression in the past). Client should call health care provider immediately if there are any thoughts of self-harm.
- NuvaRing problems (including ring slipping out or discomfort)
- Nausea/Vomiting
- Vaginal discharge
- Weight gain
- Vaginal discomfort

- Breast pain, discomfort, or tenderness
- Painful menstrual periods
- Abdominal pain
- Acne
- Less sexual desire

Other side effects seen with NuvaRing include allergic reaction, hives, and penis discomfort of the partner (such as irritation, rash, itching). Less common side effects seen with combination hormonal birth control include:

- Blotchy darkening of the skin (especially on the face)
- High blood sugar (especially in women who already have diabetes)
- High fat (cholesterol, triglycerides) levels in the blood

H. Precautions and Contraindications

The use of a combination hormonal contraceptive (CHC), like NuvaRing, is associated with increased risks of several serious side effects including blood clots, stroke, or heart attack. NuvaRing is not for women with a history of these conditions or any condition that makes the blood more likely to clot. The risk of getting blood clots may be greater with the type of progestin in NuvaRing than with some other progestins in certain low-dose birth control pills. This risk of blood clots is highest when you first start using CHCs and when you restart the same or different CHC after not using it for a month or more.

NuvaRing is also not for women with high blood pressure that medicine cannot control; diabetes with kidney, eye, nerve, or blood vessel damage; certain kinds of severe migraine headaches; liver disease or liver tumors; unexplained vaginal bleeding; breast cancer or any cancer that is sensitive to female hormones; or if the patient is or may be pregnant; or smoking females >35 years of age.

The NuvaRing does not protect against HIV or other sexually transmitted diseases.

Other serious risks include:

- Toxic Shock Syndrome (TSS). Some of the symptoms are much the same as the flu, but can become serious very quickly. Instruct the client to call the Division of Public Health Services or get emergency treatment right away with any of the following symptoms:
    - Sudden high fever
    - Vomiting
    - Diarrhea
    - A sunburn-like rash
    - Muscle aches

  - Dizziness
  - Fainting or feeling faint when standing up

- Liver problems, including liver tumors
- High blood pressure
- Gallbladder problems
- Accident insertion into bladder
- Symptoms of a problem called angioedema if the patient already has a family history of angioedema

Instruct the client to call the Division of Public Health Services right away or seek emergency medical assistance if these symptoms occur:

- Leg pain that does not go away
- Sudden shortness of breath
- Sudden blindness (partial or complete)
- Severe pain or pressure in the chest
- Sudden, severe headache unlike usual headaches
- Weakness or numbness in an arm or leg, or trouble speaking
- Yellowing of the skin or eyeballs

Do not use NuvaRing if you:

- Smoke and are over 35 years old
- Have or have had blood clots in the arms, legs, eyes or lungs
- Have an inherited problem with the blood that makes it clot more than normal
- Have had a stroke
- Have had a heart attack
- Have certain heart valve problems or heart rhythm problems that can cause blood clots to form in the heart
- Have high blood pressure that medicine cannot control
- Have diabetes with kidney, eye, nerve, or blood vessel damage
- Have certain kinds of severe migraine headaches with aura, numbness, weakness, or changes in vision, or have any migraine headaches if over the age of 35
- Have liver disease (including liver tumors) or Systemic Lupus Erythematosus
- Have unexplained vaginal bleeding
- Are pregnant or think you may be pregnant.
- Have or have had breast cancer or any cancer that is sensitive to female hormones
- Are allergic to etonogestrel, ethinyl estradiol or any of the ingredients in NuvaRing

- Need for a long period of bed rest following major surgery
- Use of Hepatitis C drug combinations containing Ombitasvir/ Paritaprevir/Ritonavir, with or without Dasabuvir, due to risk of liver enzyme elevations.

I. Method

Specific consent form signed by client for NuvaRing.

J. Clinical Record

Documentation in client's medical record of the prescription for NuvaRing as the client's method of birth control.

IV. APPLICABLE LAWS, RULES AND REFERENCES:

- Hatcher, R., Trussell, J., Nelson, A., Cates, Jr., W., Kowal, D., Policar, M., (2011), *Contraceptive Technology 20th edition*, Atlanta: Ardent Media, Inc.
- Manufacturer's website: http://www.nuvaring.com/consumer/

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ADOLESCENT SERVICES

DATE DEVELOPED: 5/2015
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/18; 6/20; 6/22; 6/24

I. POLICY:

The Division of Public Health Services' Family Planning Program provides services to all eligible clients including adolescents. The primary mission of the Family Planning Program is to reduce unintended pregnancies and improve selected health practices among low-income families. The availability of these confidential services, for adolescent clients requesting confidential services, will promote self-determination in matters of reproductive health for adolescent clients.

II. PURPOSE:

The Division of Public Health Services will provide confidential counseling and age-appropriate information to adolescent clients (under age 18 based on the North Carolina General Statutes' definition of minors) seeking contraceptive services through the Title X funded Family Planning clinic. Appointments will be made available to adolescent clients for counseling and clinical services as soon as possible when these services are requested.

III. GUIDELINES:

A. Adolescents must be assured that all Family Planning services are confidential and, if follow-up is necessary as a result of any laboratory or examination finding, every attempt will be made to assure the privacy of the individual. Adolescent clients are advised that all Family Planning services are confidential; however, they are counseled about the importance of discussing birth control needs with family including family involvement in care when possible. Additionally, adolescents are counseled about exceptions to confidentiality, based on North Carolina's laws regarding mandatory reporting of **suspected** child abuse, neglect**, child molestation, sexual abuse, rape, incest, and human trafficking**. (See Nursing Services NUR-13 Mandatory Reporting of Abuse/Neglect and Human Trafficking Policy.)

B. Minor's Consent:

1. Any minor may give effective consent for medical health services for the prevention, diagnosis and treatment of sexually transmitted disease and other diseases reportable under G.S. 130A-135, pregnancy, abuse of controlled substances or alcohol, and emotional

disturbance (NC General Statutes Chapter 90 Article 1-A-Treatment of Minors §90-21.5).

2. The Division of Public Health services may not require written consent of parents or guardians for the provision of contraceptive services to adolescent clients.

3. The Division of Public Health services cannot notify parents or guardians before or after an adolescent has requested and received confidential Title X Family Planning services.

4. Medical referral and follow-up for abnormal laboratory or physical findings other than those directly related to confidential Family Planning services will require parental consent, i.e., breast mass, elevated blood pressure, elevated blood glucose. The adolescent client will be notified of the abnormal results and advised they would need parental consent for follow-up or referral as indicated. If the client refuses to notify the parent or guardian, the Health Care Provider will notify the parent or guardian when such notification is essential to the life or health of the minor. Parental consent should be obtained for release of information for any medical referral other than those conditions stated in paragraph number one.

5. If a parent, legal guardian, or person standing in loco parentis contacts the Health Care Provider concerning treatment or medical services being provided to the minor, the Health Care Provider should request that the parent talk with the minor and then set a time to come in and talk with the Health Care Provider. The Health Care Provider should talk with the minor first and then with the parent and minor with the minor's permission.

6. Assessment of immunization status is completed for all Family Planning clients including minors. Minors will be counseled on assessed needed vaccinations, provided with vaccine information and encouraged to discuss with parents or guardians. Minors will be referred to general immunization clinic for needed vaccination.

7. Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his/her child (including vaccinations). Minors may give consent for immunizations recommended to prevent a reportable communicable disease or to prevent sexually transmitted diseases. Minors may not consent to varicella immunization as varicella is not a reportable disease in the state of North Carolina per GS 90-21.5).

C. Eligibility:

Adolescent clients receive Family Planning services based on the same eligibility guidelines as other populations; however, un-emancipated minors requesting confidential services are considered a family unit of one with charges based on his/her own income only. (See Family Planning Policy FP-1, Title X Funding Policy FP-13)

D. Services:

1. Adolescents seeking contraceptive services will be counseled on all methods of contraception. Abstinence as well as all FDA approved methods of contraception including condoms, long-acting reversible contraception and safer sex practices to reduce risks for **STIs**/HIV and pregnancy must be discussed with all adolescents. It is important not to assume that adolescents are sexually active simply because they have requested Family Planning services. As the contraceptive needs of adolescents frequently change, counseling should prepare them to use a variety of methods effectively.

2. Adolescent clients receive the same/all counseling about reproductive health that other client populations receive. **All required counseling components must be documented in the adolescent's medical record.** (See counseling/education Family Planning Policy FP-1)

3. All minors requesting Family Planning services will be provided counseling on how to resist coercive attempts to engage in sexual activities; how to prevent, correct and recognize situations of actual or suspected sexual abuse and/or sexual coercion to improve quality of life for the client.

   Definitions:

   Sexual Coercion: To force, to act or think of in a sexual way; to dominate, restrain or control in a sexual way.

   Sexual Abuse: The legal definition of abuse is satisfied if the child's parent/guardian/custodian/caretaker commits, permits, or encourages the commission of any of the following crimes against the child:

   - First- or second-degree rape
   - First- or second-degree sexual offense
   - Sexual act by a custodian
   - Crime against nature
   - Incest

- Preparation of obscene photographs, slides, or motion pictures of the child
- Employing or permitting the child to assist in a violation of obscenity laws
- Dissemination of obscene material to the child
- Displaying or disseminating material harmful to the child
- First- and second-degree sexual exploitation of the child
- Promoting the prostitution of the child

Indicators of Sexual Abuse and/or Sexual Coercion:

- Low self-esteem
- Depression
- Problems with alcohol/drugs
- Eating disorders
- Lack of trust
- Lack of assertiveness
- Hopelessness
- Anxiety
- Isolation
- Re-victimization
- Hyper-sexuality
- Perfectionism

Clinical Indicators for Sexual Coercion:

- Jealousy
- Controlling Behavior
- Misogyny (a hatred of women)
- Put-downs
- History of coercion/violence
- Problem drug/alcohol use
- Unpleasant sex
- "Gut feelings"

Steps in Short Term Counseling:

- Establish rapport with client.
- Identify clinical indicators present for sexual coercion.
- Assess client's willingness to discuss problems of sexual coercion with provider.
- Identify barriers as well as positive facilitators for counseling.

- Establish goals with client to allow provider to support and refer for counseling as needed.
- Develop action plan as well as crisis intervention to aid client in resolving problem of coercion.

. **Community and Staff Awareness of Sexual Coercion:**

- Provide information about domestic violence resources to community members as well as to employers and employees in the workplace when indicated;
- Improve screening, identification, response, and knowledge of community resources through provision of staff training
- Provide education and recommend support services for domestic violence victims and their children in relation to identified needs; and
- Educate young people about domestic violence to address the increased risk for teens and young adults, as well as the long-term consequences of witnessing domestic violence.

Prevention of Sexual Coercion/Strategies:

- Know your sexual desires and limits ahead of time. Know what is OK for you and what is not.
- Be clear with the person you're with about what your limits are. Be sure you mean what you say.
- Be alert for any warning signs.
- If you aren't sure about a new date, go out with a group of friends instead of alone.
- Don't ride alone with someone you recently met.
- Have money for bus or cab fare home. Be careful about alcohol or other drug use.
- Don't be pressured into sex.
- Trust your feelings. If you feel uncomfortable in a situation, leave right away.
- Know your neighbors. You can watch out for each other. Burglarproof your home.
- Don't let strangers into your home. Be alert.

- Stay on well-lighted streets with other people.
- Walk with confidence. Act sure of yourself and where you are going.
- If your car stalls, lift the hood and turn on the flashers. Stay in the car with the doors locked. Wait for the police or ask someone who stops to call them.

4. Adolescents must be advised of information that must be reported due to mandatory reporting laws and how this will be handled if necessary. Notwithstanding any other provision of law, no provider of services under Title X of the Public Health Service Act is exempt from any State law requiring notification or the reporting of child abuse, neglect, child molestation, sexual abuse, rape or incest and human trafficking. (See Nursing Services NUR-13 Mandatory Reporting of Abuse/Neglect and Human Trafficking Policy.)

5. Adolescents are provided counseling with intervention strategies to prevent initiation of tobacco use **if they do not already use tobacco or an electronic nicotine delivery system**. Adolescents who have already initiated use of tobacco products are counseled on use of tobacco product risks and offered tobacco cessation resources using 5A's counseling approach as requested. Intervention strategies, for adolescent clients, to prevent initiation of tobacco use/counseling on tobacco risks include:

Tobacco and Athletic Performance –

- Don't get trapped. Nicotine in cigarettes, cigars, and spit tobacco is addictive.
- Nicotine narrows your blood vessels and puts added strain on your heart.
- Smoking can wreck lungs and reduce oxygen available for muscles used during sports.
- Smokers suffer shortness of breath (gasp!) almost 3 times more often than nonsmokers.
- Smokers run slower and can't run as far, affecting overall athletic performance.
- Cigars and spit tobacco are NOT safe alternatives.

Tobacco and personal appearance –

- YUCK! Tobacco smoke can make hair and clothes stink.
- Tobacco stains teeth and causes bad breath.
- Short-term use of spit tobacco can cause cracked lips, white spots, sores, and bleeding in the mouth.
- Surgery to remove oral cancers caused by tobacco use can lead to serious changes in the face.

Know the truth –

- Despite all the tobacco use on TV and in the movies, music videos, billboards and magazines - most teens, adults and athletes DON'T use tobacco.
- Make friends, develop athletic skills, control weight, be independent, be cool…play sports.
- Don't waste (burn) money on tobacco. Spend it on CDs, clothes, computer games and movies.
- Get involved; make your team, school, and home tobacco-free; teach others; join community efforts to prevent tobacco use.

6. Contraceptive medical services (see Family Planning Policy FP-1).

REFERENCES:

Centers for Disease Control Smoking and Tobacco Use @ www.cdc.gov

North Carolina General Statues can be accessed at:
http://www.ncga.state.nc.us/gascripts/statutes/statutestoc.pl?Chapter=0900

North Carolina legislation requiring reporting of certain crimes against juveniles: Senate Bill 199/SL 2019-245 (=H596) can be accessed at**:**
http://www.ncleg.gov/BillLookUp/2019/s199

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DIAPHRAGMS

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/20; 6/22

I. POLICY:

The Division of Public Health Services may evaluate clients for diaphragms and provide a prescription for diaphragms to eligible clients including adolescents. This birth control method is indicated for the prevention of pregnancy.

II. PURPOSE:

Diaphragms are prescribed for prevention of pregnancy.

III. GUIDELINES:

A. Eligibility:

See Family Planning Policy-1 for Family Planning eligibility determination guidelines.

B. Indication and Usage:

The DHHS-Division of Public Health Services Family Planning Advanced Practice Provider (APP) may prescribe diaphragms to clients requesting this contraceptive method based on client personal/family history including medications and allergies, as well as pertinent physical examination and laboratory testing as indicated and after individualized client counseling on method side effects/contraindications and with specific instructions on method use.

C. Definition/Mechanism of Action:

A diaphragm is a dome-shaped rubber cup with a flexible rim; it is inserted into the vagina before intercourse so the posterior rim rests in the posterior fornix and the anterior rim fits snugly behind the pubic bone. The dome of the diaphragm covers the cervix; spermicidal cream or jelly is applied to the inside of the dome before insertion and the diaphragm is held in place near the surface of the cervix.

Once in position, the diaphragm provides effective contraceptive protection for up to 6 hours.

D. Effectiveness:

Based on typical use, a diaphragm will prevent pregnancy approximately 79% of the time.

E. Contraindications/Cautions:

The following conditions may preclude satisfactory use or make use of one or more of the vaginal barrier methods inadvisable:

1. Allergy to spermicide, rubber, latex, or polyurethane.
2. Abnormalities in vaginal anatomy that interfere with a satisfactory fit or stable placement.
3. Inability to learn correct insertion technique.
4. History of Toxic Shock Syndrome.
5. Repeated UTIs.
6. Need for HIV protection
7. Full term delivery within the past 6 weeks, recent spontaneous or induced abortion, or vaginal bleeding from any cause, including menstrual flow.

F. Instructions for Clients using a Diaphragm:

1. Wash hands carefully with soap and water.
2. Hold the diaphragm with the rim of the cup up.
3. Squeeze about one teaspoon of the spermicidal jelly or cream into the cup.
4. Use finger to spread the spermicide around the rim of the diaphragm.
5. Insert diaphragm carefully, it must be in the proper location in the vagina to be maximally effective.
6. Do not use petroleum jelly or oil-based vaginal creams (such as Monistat). These can make tiny holes in the diaphragm.

TO INSERT THE DIAPHRAGM:

1. Hold the diaphragm, cup up (cream/spermicidal jelly in the cup).
2. Client should use the thumb and fingers, squeeze the opposite sides of the rim together so the diaphragm folds up with the dome pointing down.

3. Put the folded diaphragm into the vagina. The best way to do this is by standing on one foot and putting the other foot up on the edge of a chair, a bathtub or a toilet. Client can also squat down or lie on back.

4. Push the diaphragm up as far as it will go.

5. Tuck the front rim up along the top of the vagina behind the pubic bone. Run index and middle finger along the rim to check for the posterior rim which should set below the cervix against the posterior wall of the vagina. Feel for the cervix through the dome of the diaphragm with index and middle finger. The cervix will feel firm but not boney. It feels like the tip of the nose.

6. Once the diaphragm is in place, client should not be able to feel it. If the diaphragm does not feel right or hurts, client should remove it and re-insert it.

7. The diaphragm can be put in up to six hours before client has sex. If it has been more than six hours since inserting the diaphragm, then client should put in more spermicidal jelly or cream. Client does not have to take the diaphragm out to do this.

WHEN HAVING SEX:

1. Leave the diaphragm in place for at least six hours after sex.

2. Do not douche.

3. Remember that the spermicidal cream or jelly only lasts about one hour.

4. If client has sex more than once, leave the diaphragm in place and put in another dose of spermicidal cream or jelly. Use the plastic stick applicator to put fresh jelly or cream in front of the diaphragm.

AFTER INTERCOURSE:

1. Check the position of the device. If it is dislodged, or seems not to be in correct position, client may want to contact clinician about emergency contraception.

2. Take the diaphragm out of the vagina 6-12 hours after sex. Client should wash hands before removal of the diaphragm. Locate the front of the rim of the diaphragm with finger. Hook finger over the rim or behind it, then pull the diaphragm down and out. Wash the diaphragm with plain soap and water, and air dry. Hold it up to the light to check for holes, tears, or cracks.

3. Do not leave the diaphragm in the vagina for more than 24 hours. This can cause infection, irritation or a complication of toxic shock syndrome.

4. Do not douche while the diaphragm is in the vagina.

G. Taking Care Of The Diaphragm:

1. Client should store supplies in a convenient location that is clean, dry, cool, and dark away from sunlight.

2. Avoid deodorant soap or perfumed soap. Do not use talcum powder on the diaphragm, or in the case.

3. Contact with oil based products can deteriorate a diaphragm. Do not use oil-based vaginal medications or lubricants when using a diaphragm or cup. Some examples include petroleum jelly (Vaseline), mineral oil, hand lotion, vegetable soil, cold cream, and cocoa butter as well as common vaginal yeast creams and vaginal hormone creams. If client needs extra lubrication for intercourse, extra spermicidal jelly is a good choice, or client can try a water-soluble lubricant specifically intended for use with diaphragms.

4. Check the diaphragm often for holes or leaks. To do this, fill the dome with water and look for tiny leaks.

5. Replace the diaphragm after 1 to 2 years. Every year the Physician Extender should check to see that the diaphragm still fits correctly. The client will need to be measured again if she has a baby, has pelvic surgery, or gains/lose more than 15 lbs.

   The client should notify the Physician Extender if she has any of the following problems:

   - Trouble urinating
   - Vaginal itching, discharge or discomfort
   - High fever (which could be a sign of toxic shock syndrome).

H. Method:

Specific consent form signed by client for diaphragm.

I. Clinical Record:

Documentation in the client's medical record of type and size of diaphragm that is prescribed for method of birth control.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: VAGINAL CONTRACEPTIVE FILM (VCF)

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/19; 6/22

I. POLICY:

The DHHS-Division of Public Health Services Family Planning Advance Practice Provider (APP) may order Vaginal Contraceptive Film for clients, including adolescents, requesting this contraceptive method based on client personal/family history including medications and allergies, as well as pertinent physical examination and laboratory testing as indicated and after individualized client counseling on method side effects/contraindications and with specific instructions on method use.

II. PURPOSE:

Vaginal Contraceptive Film, a barrier spermicide, may be used for prevention of pregnancy. Vaginal Contraceptive Film is a non-hormonal spermicide with active ingredients of 28% Nonoxynol-9 that kills sperm on contact. Vaginal Contraceptive Film is approximately 72% effective pregnancy prevention. If Vaginal Contraceptive Film is used together with condom, there will be better protection against pregnancy.

III. GUIDELINES:

A. Eligibility:

See Family Planning Policy FP-1 for Family Planning eligibility determination guidelines.

B. Indications and Usage:

1. Vaginal Contraceptive Film (VCF) may be provided to clients of the Division of Public Health Services.
2. Vaginal Contraceptive Film is not to be inserted less than 15 minutes and not more than 3 hours before intercourse. If more than 3 hours elapses since VCF inserted, then another VCF should be inserted. Use one VCF for each act of intercourse. Several VCF may be used in a day.
3. Client to be instructed on how to use VCF. An RN or LPN may counsel client on usage. (See VCF instruction sheet).

C. Contraindications:

1. Allergy to spermicidal preparations, Nonoxynol-9.
2. Inability to remember to use consistently at the time of intercourse.
3. Physical disability that causes difficulty in properly inserting film.

D. Method:

Specific consent form signed by client for barrier spermicide.

E. Clinical Record:

Documentation in the client's medical record by the Family Planning APP for Vaginal Contraceptive Film (VCF) as the client's chosen contraceptive method.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: VAGINAL SPERMICIDAL PREPARATION AND CONDOMS

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/20; 6/22

I. POLICY:

The DHHS-Division of Public Health Services Family Planning Advanced Practice Provider (APP) may order Vaginal Spermicidal Foam/Condoms for clients**,** including adolescents**,** requesting this contraceptive method based on client personal/family history including medications and allergies, as well as pertinent physical examination and laboratory testing as indicated and after individualized client counseling on method side effects/contraindications and with specific instruction on method use.

II. PURPOSE:

Vaginal Contraceptive Foam, a spermicide, may be used for prevention of pregnancy. Vaginal Contraceptive Foam is a non-hormonal spermicide with active ingredients of 12.5% Nonoxynol-9 that kills sperm. Vaginal Contraceptive Foam spermicide and condoms are prescribed for prevention of pregnancy. Condoms are also recommended for prevention of STDs.

III. GUIDELINES:

A. Eligibility

See Family Planning Policy FP-1 for Family Planning eligibility determination guidelines.

B. Definition/Mechanism of Action of Spermicide

1. Spermicide - A birth control method which kills sperm. There are many kinds of spermicides, foam, jelly, cream, suppositories and film.

2. Spermicides cover the cervical os and kill sperm. Nonoxynol-9, the active chemical agent in spermicide products available in the United States, is a surfactant that destroys the sperm cell membrane.

C. Effectiveness

- When used correctly spermicides have an approximately72% pregnancy prevention effectiveness rate based on typical use. If a spermicide is used with a condom it may increase the effectiveness rate up to 98%.

D. Contraindications/Cautions

1. Allergy or sensitivity to the spermicidal agent or to ingredients in the base

2. Inability to learn correct insertion technique

3. Abnormal vaginal anatomy (such as vaginal septum, prolapsed uterus, or double cervix) that interferes with appropriate placement or retention of spermicide.

   Caution: Client with possibility of HIV. If Nonoxynol-9 is used, many times a day or if irritation occurs with use, irritated tissues may increase risk of HIV and other STD's.

E. Instructions for Clients using Spermicide

1. Client must use a spermicide every time with intercourse for optimal effectiveness. Be sure spermicide is in place before partner's penis enters the vagina.

2. If client has subsequent problems with vaginal or penile irritation, client may want to try a different spermicide product. Client could switch to condoms or see the APP provider for another method of birth control.

3. Clients should use condoms along with spermicide if desired. By using this combination, contraceptive protection will be more effective and the risk of sexually transmitted infection is greatly reduced.

   a. Common errors in spermicide use
   Common errors can lead to unintended pregnancy:

      (1) Failing to use spermicide or an alternative method such as condoms each and every time intercourse occurs, even when menstrual bleeding is present.
      (2) Failing to place spermicide high enough in the vaginal vault to be effective.
      (3) Failing to wait long enough after insertion for suppositories, foam, or film to dissolve and disperse.
      (4) Failing to use another application of spermicide after effectiveness has lapsed.
      (5) Using too little spermicide or foam, or failing to shake the foam can vigorously enough.
      (6) Failing to use another applicator with every repeated act of intercourse.

(7) Failing to recognize that the foam bottle or spermicide tube is empty.
(8) Failing to have spermicide available.

b. Before Intercourse

(1) Check to be sure you have all the supplies you need. If you are using foam, cream, or gel, you may also need a plastic applicator. If you use foam, keep an extra container on hand. You may not be able to tell when your current container is running low.
(2) Plan ahead regarding when to insert your method. Try to find a routine that is comfortable for you and your partner. If you are using suppositories, or film, a waiting period between insertion and intercourse is essential to allow the product to melt or spread inside your vagina. The package instructions explain the exact time required. One dose of most spermicide formulations remains effective for 1 hour. If a longer time has passed, or if you have intercourse again, you must use a new dose of spermicide.

c. For Insertion

(1) Wash your hands carefully with soap and water.
(2) Foam – Shake the foam container vigorously at least 20 times then use the nozzle to fill the plastic applicator.

Gel, Cream, or Foam – Fill the applicator by squeezing the spermicide tube. Next insert the applicator into your vagina as far as it will comfortably go; then, holding the applicator still, push the plunger to release the gel, cream, or foam. The spermicide should be deep in your vagina, close to your cervix.

(3) Always lie down when you put the spermicide into your vagina. If you stand or walk around, you need to put another application of the spermicide into your vagina before having sex.

Suppository - Remove the wrapping and slide the suppository into your vagina. Push it along the back wall of your vagina as far as you can so it rests on or near your cervix.

With any type of spermicide, you need to insert the spermicide before your partner's penis touches your vaginal opening or comes into close contact with the vaginal opening.

Film – Be sure your fingers are completely dry. Place one sheet of film on your fingertip and slide it along the back wall of your vagina as far as you can so the film rests on or near your cervix.

(4) Repeated intercourse. Apply a new application of spermicide each time you have intercourse. Alternatively, you can switch to condoms for repeated intercourse if you wish.

(5) After intercourse. Leave spermicide in place for at least 6 hours after intercourse; do not douche or rinse your vagina. Douching is not recommended, but if you choose to douche you must wait at least 6 hours.

F. Definition and Mechanism of Action of the Condom (male condom)

- Condom (male condom) - A thin sheath placed over the glands and shaft of the penis to act as a physical barrier.

G. Mechanism of Action

- The condom prevents pregnancy by blocking the passage of semen and is effective only when used from "start to finish" during every act of intercourse.

H. Effectiveness

- When used correctly condoms have an approximately 82% pregnancy prevention effectiveness rate based on typical use.

I. Contraindications

- Allergy to component of the condom

  * Condom options. The Division of Public Health Services will carry latex condoms. Clients who are allergic to latex should be advised of the polyurethane condom. Natural membrane condoms are available but do not provide the same level of protection against STI's. Clients would have to purchase polyurethane and natural membrane condoms at a private facility.

J. Instructions for Using Condoms

Use latex or plastic condoms when you have any concern about reproductive tract infections, including infection with the human immunodeficiency virus (HIV). When used consistently and correctly, condoms also provide good protection against unintended pregnancy.

1. Before Intercourse

   a. Have on hand an adequate supply of latex or plastic condoms and water-based lubricant if you might use one for intercourse, even if you plan to use another contraceptive. Have extra condoms available in case the first is damaged or torn before use or put on incorrectly or if you have repeated intercourse.
   b. Discuss condom use before you have intercourse.

2. At Time of Intercourse

   a. Open the condom package carefully to avoid damaging it with fingernails, teeth, or other sharp objects.
   b. Put on the condom before the penis comes in contact with the partner's mouth, anus, or vagina. If the penis is uncircumcised, pull the foreskin back before putting on the condom. Keep the condom on the penis until after intercourse or ejaculation.
   c. Unroll the condom a short distance to make sure the condom is being unrolled in the right direction. The rolled ring should be on the outside. Then hold the tip of the condom and unroll it down to the base of the erect penis. If the condom does not unroll easily, it is on upside-down and may expose the partner to infectious organisms contained in the pre-ejaculate. Discard and begin with a new condom.
   d. Adequate lubrication is important. For latex condoms, use only water-based lubricants like water; lubricating jellies (e.g., K-Y Jelly); or spermicidal creams, jellies, foam, or suppositories. Avoid oil-based lubricants like cold cream, mineral oil, cooking oil, petroleum jelly, body lotions, massage oil, or baby oil that can damage latex condoms. For plastic condoms, any type of lubricant can be used.
   e. If the condom breaks of falls off during intercourse but before ejaculation, stop and put on a new condom. A new condom must also be used when you have prolonged intercourse or different types of intercourse within a single session (e.g., vaginal and anal).

3. After Intercourse

a. Soon after ejaculation, withdraw the penis while it is still erect. Hold the condom firmly against the base of the penis to prevent slippage and leakage of semen.
b. Check the condom for visible damage such as holes, then wrap it in tissue and discard. Do not flush condoms down the toilet.
c. If the condom breaks, falls off, leaks, or is not used:

    i. Discuss the possibility of pregnancy or infection with your partner and contact your health care provider as soon as you can. Do not douche. Emergency contraception may be used to prevent pregnancy if started within 120 hours (5 days) of having unprotected intercourse. Call 1-888-NOT-2-LATE (1-888-668-2-5283) to learn more about emergency contraceptives and to obtain phone numbers of providers of emergency contraception nearest to you, obtain this information from the World Wide Web at not-2-late.com Emergency Contraception Website & Hotline or contact the Division of Public Health Services.
    ii. Gently wash the penis, vulva, anus, and adjacent areas with soap and water immediately after intercourse to help reduce the risk of acquiring an STD. Then insert an applicator full of spermicide into the vagina as soon as possible.

K. Female condoms are not available through the Division of Public Health Services. Clients may obtain female condoms from a private vendor if desired.

L. Method:

Specific consent form signed by client for vaginal spermicide preparation and/or condoms.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DEPO–PROVERA (DMPA) CONTRACEPTIVE INJECTION

DATE DEVELOPED: 6/96
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/22

I. POLICY:

The Division of Public Health Services may provide injectable contraceptives to Family Planning eligible clients including adolescents. Depo-Provera is indicated for prevention of pregnancy and will be available to all eligible clients.

II. PURPOSE:

This method of birth control is prescribed to clients for prevention of pregnancy.

III. GUIDELINES:

A. Eligibility:

See Family Planning Policy-1 for Family Planning eligibility determination guidelines.

B. Indication and Usage:

1. Depo-Provera may be offered to any female client in Family Planning Clinic who desires highly effective, longer term, reversible contraception.

2. Absolute contraindication to use of Depo-Provera:

   - Current breast cancer

3. Contraindications/Cautions; (risks usually outweigh benefits)

   a. Newly diagnosed/current cardiovascular Disease
   b. Abnormal liver function or liver tumors; liver disease
   c. History of breast cancer
   d. Unexplained vaginal bleeding prior to evaluation
   e. Active thrombophlebitis, or current or past history of thromboembolitic disorders or cerebral vascular disease.
   f. Known or suspected pregnancy
   g. Known hypersensitivity to Depo-Provera Cl (medroxyprogesterone acetate) or any of its other ingredients

4. Exercise caution if Depo-Provera injection is used or considered in the following situations and carefully monitor for adverse effects.

    a. Pregnancy planned in fairly near future
    b. Concern over weight gain
    c. According to the WHO, "since the effect of DMPA (depo medroxyprogesterone acetate) on BMD (bone mineral density) is largely reversible, any lifetime increase in fracture risk is likely to be small". However, women with medical co-morbidities that place them at high risk for osteoporosis and fracture, such as chronic corticosteroid use, disorders of bone metabolism, a strong family history of osteoporosis (that may represent a genetic mutation associated with fractures) or women with anorexia nervosa may not be well suited for long-term DMPA use.

        Women initiating DMPA should be thoroughly counseled about the benefits and potential risks of DMPA. Daily exercise and age appropriate calcium and Vitamin D intake should be encouraged.

        No studies show that these measures will affect loss of BMD during DMPA use but these recommendations can benefit general health.

5. Initiation of Method:

    a. Depo-Provera may be started at any time the Advanced Practice Provider (APP) can be reasonably certain the client is not pregnant.
    b. A health care provider can be reasonably certain that a woman is not pregnant if she has no signs or symptoms of pregnancy and meets any one of the following criteria:

        - is ≤7 days after the start of normal menses
        - has not had sexual intercourse since the start of last normal menses
        - has been correctly and consistently using a reliable method of contraception
        - is ≤ 7 days after spontaneous or induced abortion
        - is within 4 weeks postpartum
        - is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥ 85%] of feeds are breastfeeds), amenorrheic, and < 6 months postpartum

    c. Exceptions to this initiation schedule:

(1) Post abortion (spontaneous or induced) clients can begin Depo-Provera within 7 days of the termination. Clients should abstain from sexual intercourse or use additional back-up contraceptive, such as condoms, for the next 7 days unless the injection is given at the time of a surgical abortion. Clients who have had a positive pregnancy test and terminated the pregnancy need to provide/authorize access to documentation of the termination of pregnancy.

(2) Quick Start method may be initiated by the APP. The Goal of Quick Start is to provide maximum contraceptive protection as soon as possible rather than waiting for the next menstrual period. The APP may initiate Depo-Provera contraception the same day as requested when the clients are most likely to be motivated. The client will be evaluated before initiation of quick starting Depo-Provera by: assessing the last menstrual period and most recent unprotected sex; obtaining urine pregnancy test as indicated by history; assessing eligibility for emergency contraception and offer as indicated; obtaining blood pressure and weight and conduct appropriate screening history to determine any method specific contraindication if unable to complete a full exam/visit. Clients who receive the quick start method of Depo-Provera contraceptive may benefit from a urine pregnancy test two to four weeks after initiation of the method.

d. A negative urine pregnancy test should be obtained just prior to the initial injection for all clients (exception post-TAB clients within one week of termination).

e. Give 150 mg of Depo-Provera IM in the deltoid or gluteus maximus muscle or give Depo-Sub Q Provera 104 mg per subcutaneous administration in the abdomen or upper thigh. Do not massage/rub the IM or SQ injection sites. Type of injection given will depend on order per APP

f. A back-up method is required for 24 hours only if Depo-Provera is given within 5 days of the onset of the menses (exception immediate post-TAB clients). Back-up protection is required for 1week if Depo-Provera is given later than day 7 in the menstrual cycle or as directed by APP; clients may need to receive a follow up pregnancy test several weeks later to diagnose pregnancy in a timely fashion. Follow up pregnancy test per APP recommendations.

6. Clients who receive the Depo-Provera 150 mg IM will return for repeat injection every 11-13 weeks and annually for preventive visit/ physical exam.

   Clients who receive the Depo-Sub Q Provera 104 mg SQ will return for repeat injection every 12-14 weeks and annually for preventive visit/physical exam.

7. If greater than 13 weeks (91 days) has elapsed since the last injection with Depo-Provera 150 mg IM (92-97 days), a negative urine pregnancy test must be obtained prior to receiving the next injection.

   If greater than 14 weeks (98 days) has elapsed since the last injection with Depo-Sub Q Provera 104 mg (99-104 days), a negative urine pregnancy test must be obtained prior to receiving the next injection.

8. If more than 14 weeks (98 days or more) has elapsed since the last injection of Depo-Provera 150 mg IM or 15 weeks (105 days or more) has elapsed since last injection of Depo-Sub Q Provera 104 mg:
   - A urine pregnancy test will be obtained; serum pregnancy test per APP order, sexual health history completed including risk for pregnancy with recommendation for continuation of Depo-Provera method per APP.

9. Method Changes:

   a. Clients who are currently using Depo-Provera IM and wish to begin OCs will be instructed to start the OCs when the next Depo Provera injection is due (11-13 weeks). Clients may begin OCs as late as 13 weeks following the last injection but will need to use a back-up method for the first cycle of OCs.
   b. Clients who are currently using Depo-Sub Q Provera 104 mg and wish to begin OCs will be instructed to start OCs on the 13^{th} to 14^{th} week following their last injection.
   c. Clients who are currently using Depo-Provera and wish to receive an IUD may schedule an insertion appointment at any time during the 11-13 weeks for Depo Provera 150 mg IM or 12-14 weeks for Depo-Sub Q Provera 104 mg following the last injection.

10. Serious side effects that should be reported:

    a. Heavy bleeding
    b. Repeated, very painful headaches

c. Blurred vision, double vision or loss of vision
d. Severe chest, stomach or leg pain
e. Lower abdomen pain - pregnancy symptoms
f. Allergic reaction/site reaction (pus, prolonged pain, redness, itching or bleeding at injection site – may be a sign of infection)
g. Severe depression

11. If a client discontinues Depo-Provera and wants to avoid pregnancy, information concerning other methods will be reviewed with client; client and clinician can decide on a method.

12. The effects of smoking while using Depo-Provera are not known. Advise no smoking.

13. If a pregnancy is desired, injection should be discontinued 6-12 months before desired conception. Average delay in return of fertility is about 10 months from the last injection. Depo-Provera does not decrease fertility long term**.**

C. Method:

Specific consent form signed by client for Depo-Provera contraceptive injection.

D. Clinical Record:

Documentation by the RN or LPN who administers the client Depo-Provera injection including dosage, route and site of injection, as well as return date for next clinical follow-up/visit injection must be recorded in the client's medical record.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ORAL CONTRACEPTIVES

DATE DEVELOPED: 10/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/22

I. POLICY:

The Division of Public Health Services may provide oral contraceptives to eligible Family Planning clients including adolescents. Oral contraceptives are indicated for prevention of pregnancy and will be available to eligible clients.

II. PURPOSE:

This method of birth control is prescribed to clients for prevention of pregnancy. The type of oral contraceptive prescribed for a client will be determined by the Advanced Practice Provider (APP). Changes in prescription will be made by the APP if needed due to side effects of oral contraceptives.

III. GUIDELINES:

A. Eligibility:

See Family Planning Policy-1 for Family Planning eligibility determination guidelines.

B. Indication and Usage:

Oral contraceptives are taken on a daily basis at approximately the same time each day. Oral contraceptives are indicated for prevention of pregnancy and are 91-99% effective based on typical use. Family Planning staff instruct client on usage of oral contraceptives including management of missed pills and other medication interactions utilizing media approved birth control education fact sheets. Oral contraceptives do not protect against HIV or other sexually transmitted diseases.

C. Prescribing/Dispensing Oral Contraceptives:

1. The APP may prescribe a full year of oral contraceptives to a new client initiating this birth control method, as well as to clients with prior experience in use of oral contraceptives, based on the individual client's evaluation and assessed understanding of use of oral contraceptives.
2. New Family Planning clients desiring oral contraceptives who are determined to need further evaluation of appropriate use may be

given a limited prescription/supply of oral contraceptives by the APP at the first visit based on individual client evaluation/assessment.

a. Clients given an initial limited prescription/ supply of oral contraceptives will be instructed to return before supply runs out for medical evaluation of the method. If there are no contraindicating factors, the client will be given remaining oral contraceptive prescription/supply of her original prescription to complete a 1 year order (depending upon expiration date of the oral contraceptives when dispensed from the Division of Public Health Services Pharmacy).

b. Clients continuing oral contraceptives at the second annual examination will be prescribed a full year (13 packages) of oral contraceptives unless contraindicated based on client evaluation and assessed understanding of oral contraceptive use.

c. Clients prescribed a year of oral contraceptives may be dispensed 6 months with a refill of 7 months (generally due to short expiration dates of pills when dispensed from the Division of Public Health Services Pharmacy). Clients starting/resuming/ continuing oral contraceptives are counseled to report any problems or adverse effects with use of oral contraceptives.

3. Clients who are on oral contraceptives should have annual preventive visits. If circumstances prevent the client from coming in for an annual preventive visit, she may be given one package of current oral contraceptive by a registered nurse per standing order to fill the gap in time until the annual preventative visit. (See Family Planning Standing Order ST-FP-1)

4. A client should be given no more than 3-packages of oral contraceptives before the annual preventive examination is completed when this exam is overdue. This should be done at the discretion of the APP or medical director.

5. Clients transferring from a private physician or from another Family Planning Program may be scheduled for a pill supply visit if they will run out of pills before a physical can be scheduled. There must be objective data documented that the client is on oral contraceptives and there are no contraindicating factors. A prescription to continue oral contraceptives is provided by the APP after review of client's medical records and physical assessment as indicated; physical exam will be scheduled to meet client needs. Routinely the client should be given 3 packages of pills. There may be circumstances in which this may

need to be altered. This should be done at the discretion of the APP or medical director.

6. Breastfeeding mothers may be started on progestin-only contraceptives at 6 weeks postpartum if there are no contraindicating factors. If mother notes a decrease in milk flow she should discontinue oral contraceptives and choose another method of birth control after evaluation by the APP.

D. Quick Start or Same Day Start Method for Initiation of Birth Control Methods:

1. Combined Oral Contraceptives
2. Progestin Only Pills

The APP utilizes client subjective data as well as objective findings obtained during client assessment/evaluation to reasonably ascertain the client is not pregnant. The Quick Start method may then be an appropriate option in some medical situations but not all. Subjective and objective findings provide guidance in determination on use of Emergency contraception or oral contraceptive start with menstrual cycle.

The client should be counseled concerning the possibility of break through bleeding and use of back up method for the appropriate time.

E. Medical Conditions Precluding Combined Oral Contraceptive Use:

1. Thrombophlebitis or thromboembolic disorders (or history thereof)
2. Cerebrovascular disorders (or history thereof)
3. Ischemic heart disease or coronary artery disease (or history thereof)
4. Valvular heart disease with complications
5. Hypertension
6. Diabetes with vascular involvement
7. Headaches with focal neurological symptoms (migraines with aura)
8. Carcinoma of the endometrium
9. Undiagnosed abnormal genital bleeding
10. Cholestatic jaundice of pregnancy
11. Jaundice with prior pill use
12. Hypersensitivity to any component of the product
13. Major surgery with prolonged immobilization
14. Known or suspected carcinoma of the breast (or history thereof)
15. Known or suspected estrogen-dependent neoplasia (or history thereof)
16. Pregnancy, known or suspected

17. Benign or malignant liver tumor (hepatic adenomas) (or history thereof)
18. Age 35 and > and smoker for combined oral contraceptives

F. Contraindications for POPs (Progestin Only Pills)

1. Breastfeeding women less than 6 weeks postpartum
2. Current deep venous thrombosis or pulmonary embolus
3. History of bariatric surgery (malabsorptive procedures)
4. Systemic lupus erythematosus with positive or unknown anti-phospholipid antibodies
5. Severe (decompensated) cirrhosis, benign or malignant liver tumors
6. Current or past breast cancer
7. Use of ritonavir-boosted protease inhibitors, certain anticonvulsants, (phenytoin, carbamazepine, barbiturates, primidone, topiramate, ox-carbazepine), rifampicin or rifabutin

In addition, POPs should be stopped if the client develops ischemic heart disease, stroke, or migraine with aura while using POPs.

G. Method:

Specific consent form signed by client for oral contraceptives.

H. Clinical Record:

Documentation in the client's medical record of the prescription for the specific type of oral contraceptive and the number of packages with any refills ordered as the client's method of birth control.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMERGENCY CONTRACEPTIVES

DATE DEVELOPED: 4/2014
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/15; 6/16; 6/17; 6/18; 6/20; 6/22

POLICY:

The Division of Public Health Services' Family Planning Program, under Title X guidelines, provides services to eligible clients, including adolescents. The Family Planning Program supports a wide range of preventative and contraceptive services to promote self-determination in matters of reproductive health and to ensure that all pregnancies are intended.

PURPOSE:

To provide Emergency Contraceptive to eligible Family Planning clients, including adolescents, who are on birth control methods with known user failure potential (i.e., combined oral contraceptives, progestin only oral contraceptives, contraceptive vaginal ring, male and female condoms, Depo-Provera, diaphragm, withdrawal, spermicide or no method) as an effective measure in preventing unintended pregnancy.

GUIDELINES:

Emergency Contraceptive Pills (ECPs):

A. Emergency Contraception Client Education:

Educating clients about the availability of ECPs in advance of need is an important aspect of Emergency Contraceptive service delivery. For ECPs to be effective at preventing unintended pregnancy clients must know:

1. That ECPs are an available option if their regular birth control was not taken or used correctly;

2. That ECPs can be used within 3-5 days (120 hours) of unprotected sex, not just the morning after;

3. How to obtain ECPs when they need them:

- Clients will be made aware of the availability of Emergency Contraceptives over the counter.
- Clients of any age would be able to obtain ECPs over the counter without a prescription.
- Clients can receive a prescription for ECPs to be able to obtain them at a private pharmacy if needed. (*Clients having Medicaid or private insurance are provided with a prescription for ECP, sent to the client's pharmacy of choice.)

Clients will be advised if they do not have the capability to buy ECPs they should call the Division of Public Health Services within the appropriate time frame for an appointment for evaluation and ECPs.

4. The copper T380A IUD is effective for emergency contraception if inserted within 5 days after unprotected intercourse.

   - Clients who desire this as a continued method of birth control would be a candidate to use this method.
   - A medical provider is required to insert the method. If the client expresses interest in the Copper IUD, contact the provider to see if it is possible to schedule the client within the appropriate timeframe for insertion.

B. When is Emergency Contraception Needed?

No contraceptive method is fail-safe and few couples can use their method perfectly every time they have intercourse. Emergency contraception provides an important safety net when:

1. A condom breaks
2. No birth control is used
3. A woman misses 2 or more birth control pills in a row or starts a pack 2 or more days late
4. A diaphragm slips out of place
5. A woman is more than 2 weeks late for a contraceptive injection
6. A woman is raped

Emergency contraception (Plan B) should be taken within 72 hours (3 days) of unprotected sex. Emergency Contraception (ELLA) can be used up to 120 hours (5 days).

EPCs should not be used in place of ongoing, correct use of regular contraceptives because it is less effective. EPCs provide no protection for sexually transmitted diseases.

C. EPCs - Client Counseling

Counseling of a client requesting EPCs should include the following information:

1. Exclude the possibility a woman may already be pregnant: assess the date of the last menstrual period and whether it was normal. Establish the time of the first episode of unprotected intercourse to ensure she is within the treatment time frame 72 hours (3 days) for Plan B or 120 hours (5 days) for ELLA.

2. Make certain that the client does not want to be pregnant

3. Explain how to take ECPs correctly

4. Describe potential side effects of EPCs.

5. Explain emergency contraception is for emergency only

6. Explain EPCs do not protect against or treat STDs. Recommend screening and treatment for STDs if indicated.

7. Remind the client to begin using ongoing contraception. This is very important due to the fact that she may be at high risk of pregnancy following EPC use if ovulation was delayed.

8. Inform the client that her period most likely will come on time but may begin a few days earlier or later than normal.

9. Inform the client that emergency treatment can fail. Ask the client to return for a pregnancy test if her period is delayed more than four weeks after treatment.

10. Provide written instructions.

11. Encourage the client to call if she has any questions.

12. Have client to sign written informed consent.

13. Inform client that ECPs do not provide protection from pregnancy during the treatment cycle. Inform client ECPs are not an effective ongoing birth control. Discuss ongoing birth control methods and how to use them.

14. Advise the client her next period may start a few days earlier or later than usual. If a period doesn't start within four weeks, see the medical provider for an exam and pregnancy test. If you think you may be pregnant, see your clinician at once, whether or not you plan to continue the pregnancy. ECPs may not prevent an ectopic pregnancy (in the tubes or abdomen). Ectopic pregnancy is a medical emergency.

15. Counsel the client to begin using a reliable method of birth control. ECPs are meant for one-time, emergency protection. They are not an effective form of birth control. Clients choosing to resume use of a birth control method after taking ECPs should consult the Advanced Practice Provider (APP) for instructions.

16. Counsel at-risk clients on prevention of HIV and sexually transmitted infections as well as pregnancy; use condoms correctly and consistently if at risk.

D. Medical Evaluation Before Emergency Contraception:

*Note: Plan B may be less effective in women with an elevated BMI. ELLA may be recommended for women with an elevated BMI when available.

The following evaluation/medical procedures will be performed as indicated:

1. Client/family medical and social/sexual history, allergies; medications
2. Pregnancy Test
3. Pelvic Exam
4. Screen for STD as indicated
5. Referrals (i.e., Emergency Room for rape victim, Department of Social Services, Mental Health, HELP, etc.)

E. Plan B – One-step and ELLA may be used for emergency contraception

Plan B treatment schedule is one dose within 72 hours (3 days) after unprotected sex. ELLA can be prescribed within 120 hours (5 days) of unprotected sex. Plan B One-step/ELLA will be dispensed from the Division of Public Health Services' Pharmacy as emergency contraceptive for eligible FP clients, including adolescents per the APP's order. Prescriptions will be provided for insured clients to fill at an outside pharmacy.

Instruct clients regarding the following possible complications of ECPs:

Watch for warning signs for the next couple of weeks. Seek emergent care at once if you develop:

- severe pain in your leg (calf or thigh)
- severe abdominal pain
- chest pain or cough or shortness of breath
- severe headaches, dizziness, weakness, or numbness
- blurred vision, loss of vision, or trouble speaking
- jaundice (yellowing of the skin)

F. Follow-up after using ECP Treatment

Follow-up may be necessary if:

1. The client experiences symptoms that suggest possible complications or has any concerns.
2. The client has not menstruated within four weeks after treatment. If ECPs have failed and the woman is pregnant, advise her of the possible options. Refer her to other service providers as appropriate.
3. The client needs another visit to initiate a regular method of contraception.
4. The client requests further information or counseling about preventing pregnancy or STD infection.

G. Initiating Ongoing Contraception After ECP Use:

Because ECPs can delay ovulation, a woman could be at risk of pregnancy in the first few days after treatment. Women should use a back-up method of contraception for the remainder of the treatment cycle then initiate a regular method

of contraception with their next menstrual cycle as directed by the APP according to method client chooses to initiate after using ECPs.

Method	When to Initiate
Condom	Can be used immediately
Diaphragm	Can be used immediately
Spermicide	Can be used immediately
Sponge	Can be used immediately
Oral Contraceptive (OC)	Oral contraceptive: Begin use as directed by the APP.
Injectable	Initiate the day ECP treatment is initiated or the day following ECP is completed or initiate within 7 days of beginning the next menstrual period. If starting immediately after ECP use, abstain from intercourse or use back-up protection for the first 7 days.
Vaginal Ring	Initiate the day after ECP treatment is completed or within 5 days of beginning the next menstrual period. If starting immediately after ECP use, abstain from intercourse or use back-up protection in addition to the ring for the first 7 days.
Intrauterine Device (IUD)	Insert the levonorgestrel IUD the day ECP treatment is initiated or the day after ECP treatment is completed or within 7 days of beginning the next menstrual period. If starting immediately after ECP use, abstain from intercourse or use back-up protection for the first 7 days. Consider inserting a copper T380-A IUD for emergency contraception rather than using Emergency Contraception Pills if this is client's method of choice and there are no contraindications to a copper T380-A IUD.
Fertility Awareness	Initiate after onset of the next normal menstrual period and after the client has been trained in using the method.
Sterilization	Perform the operation any time after pregnancy has been ruled out.
Implants	Initiate the day ECP treatment is initiated or the day after ECP treatment is completed or within 7 days of beginning the next menstrual period. If starting immediately after ECP use, abstain from intercourse or use back-up protection for the first 7 days.

H. Use of ECPs by a Lactating Client:

The effect of one-time ECP use on milk production in lactating women has not been studied. As an alternative to combined ECPs, the progestin-only ECP regimen can be used. If the client does not want to expose her infant to artificial hormones through breast milk, she could manually express the milk and bottle feed for 24 hours after treatment.

NOTE: Clients who are using the lactational amenorrhea method, those within six months post-partum, who are fully breastfeeding (no supplemental feeding with solid foods or a bottle), and whose menstruation has not resumed, have decreased fertility and may not require ECP treatment.

Recommendations about use of ECPs should be made with this in mind.

I. ECPs and Drug Interactions:

It is not known whether drug interactions are associated with one time, short-term ECP use.

J. ECPs – Contraindications:

Pregnancy, known or suspected

K. Method:

Specific consent form signed by the client for ECP.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TITLE X FUNDING

DATE DEVELOPED: 6/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/20; 6/22; 6/24

I. POLICY:

The Division of Public Health Services will offer a broad range of acceptable and effective medically approved **contraceptive** methods and services. Utilization of Title X funding affords the Division of Public Health Services assurance in provision of these methods and services to as many Family Planning eligible clients**,** including adolescents, as possible. Clients may receive methods of contraception that have been approved by the Federal Food and Drug Administration. **The Division of Public Health Services will adhere to Title X program requirements in project management and administration.**

II. PURPOSE:

A. To enable persons who want to obtain Family Planning care to have access to such services with priority given to persons from low-income families.

B. To provide individuals the information and means to exercise personal choice in determining the number and spacing of their children.

C. All services provided will be of high quality and be competently and efficiently administered.

III. GUIDELINES:

A. Definition

The Law surrounding this grant enables persons who want to obtain Family Planning care to have access to such services. Congress enacted the Family Planning Services and Population Research Act of 1970. Public Law 91-572 Section 1001 of the Act authorizes grants "to assist in the establishment and operation of voluntary Family Planning projects which shall offer a broad range of acceptable and effective Family Planning methods and services (including natural Family Planning methods, infertility services, and services for adolescents)". Abortion cannot be considered as a method of contraception based on Title X guidelines.

The mission of Title X is to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children through the provision of affordable, voluntary Family Planning services.

B. Service Requirements

1. Legal Issues

a. The Division of Public Health will advise the NC DPH **Reproductive Health Branch** in writing of any research projects involving Title X clients.
b. Personnel must be informed that they may be subject to prosecution under Federal Law if they coerce or endeavor to coerce any person to undergo any abortion or sterilization procedure.
c. See Family Planning Policy FP-1 for other Title X service requirements.

2. Financial Management

a. Documentation must be maintained on all income and expenditures.
b. Clients must not be denied services or be subjected to any variation in quality of services because of the inability to pay. Billing and collection procedures must have the following characteristics:
(1) Charges must be based on a cost analysis of all services provided by the health department. At the time of services, clients who are responsible for paying any fee for their services must be given bills directly. In cases where a third party is responsible, bills must be submitted to that party **without the application of discounts**.
(2) A schedule of discounts must be developed and implemented with sufficient proportional increments so that inability to pay is never a barrier to service.

A schedule of discounts is required for individuals with family incomes between 101% and 250% of the Federal poverty level. **These clients shall not pay more in co-payments or additional fees than they would otherwise pay when the schedule of discounts is applied. The schedule is reviewed and updated annually.**

Fees may be waived for individuals with family incomes above 100% of the Federal poverty level who, as determined by the health director, are unable, for good cause, to pay for Family Planning services. Individual clients meeting waiver of fees, as determined by the health director **or designee**, will

have waiver documentation completed in the client electronic health record. Clients meeting waiver of fees criteria will be notified of waiver of charges by agency billing staff.

For persons from families whose income exceeds 250% of the FPL, charges must be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services. Title X Family Planning clients cannot be denied services because of outstanding account balances or for failure to bring in verification of income. The Division of Public Health Services may use reported income through other programs offered within the agency rather than re-verify income or rely solely on the client's self report.

(3) Clients whose **family** income is at or below 100% of the Federal poverty level must not be charged, although the agency must bill third parties authorized or legally obligated to pay for services.

(4) Individual eligibility for a discount must be documented in the client's financial record.

(5) Bills to third parties must show total charges without applying any discount, unless there is a contracted reimbursement rate clients will be billed per third party agreement. Family income should be assessed before determining whether copayments or additional fees are charged. With regard to insured clients, clients whose family income is at or below 250% FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied.

(6) Where reimbursement is available from Title XIX or Title XX of the Social Security Act, a written agreement with the Title XIX or the Title XX state agency is required.

(7) Bills to clients must show total charges less any allowable discounts at time of visit.

(8) Reasonable efforts to collect charges without jeopardizing client confidentiality must be made.

(9) Eligibility for discounts for un-emancipated minors who receive <u>confidential</u> services must be based on the income of the minor. The Division of Public Health Services may not have a "no fee", or "flat fee" for provision of services to minors, or a

schedule of fees for minors that is different from other populations receiving Family Planning services.

(10) Client income and eligibility **for discounted** services should be re-evaluated at least annually. Clients must be informed of need to bring in verification of income information at the time of appointment.

(11) Verification of client income may not burden clients with low incomes or impede access to care. If client income cannot be verified through access to enrollment in other DHHS agency programs or after reasonable attempts for verification, client charges must be based on the client's self-reported income. **For clients refusing to provide self-reported income, the agency may**:

a. Assure clients that income information is strictly used to determine SFS eligibility for discounts on charges for Family Planning services, and information is not shared outside the agency
b. Offer option of income range declaration rather than specific dollar amount
c. Inform client that income reported to other agency programs may be used in lieu of client's declared income, and that reported income will be used
d. Advise the client if no other agency program income has been reported and the client continues to refuse to **verbally** declare income, the client will be charged 100 % of the fee for services rendered without any discount
e. If client states inability to pay 100% of fees for services, explain eligibility for discounts determined by income and offer another opportunity to declare income
f. Document conversation and outcome clearly and thoroughly in the client's record.
g. Complete and have client sign a declination of provision of any declared income and understanding of service charge at 100% due to undeterminable eligibility for discounts in absence of a declaration of income.

(12) Clients who report they have no income are not required to provide absence of income, but may be

asked about how they pay for living expenses. Incomes from persons who support the client financially may be verified. **Clients may verbally declare income of persons supporting the client financially if unable to provide verification of support person(s) income.** Services will not be denied on day of appointment for failure to provide verification of income.

(13) Health Departments are exempt from requirements for collecting a Medicaid co-payment.

(14) The Division of Public Health Services may utilize NC Debt Setoff as an acceptable means for collecting past due amounts for Family Planning clients provided doing so does not jeopardize confidentiality.

(15) Charges for non-essential supplies or replacement cycles of pills are determined using the sliding fee scale on such charges when incurred.

(16) 340B drug discount programs may not be used to purchase medications for non-Title X projects. (See B-1 Fee, Eligibility requirements, and billing Policy)

C. Services of Care

Please refer to policy "Family Planning Program Policy FP-1" for program criteria and a detailed explanation of services rendered.

D. Informational and Educational Materials

1. The Division of Public Health is required to have a review and approval process of all informational and educational materials developed or made available to Family Planning clients prior to their distribution. An advisory committee utilized to review educational materials must be broadly representative of the population or community for which the materials are intended.

   a. This Advisory Committee must consist of at least 5 members. These members are broadly representative of the community.
   b. The Division of Public Health Services will use rolling media review to determine media usage by utilizing clinical clients for review of educational materials to assure appropriateness of materials for the population being served.
   c. Any publications or other media developed by the Division of Public Health Services using Federal Title X funds will acknowledge Title X Federal grant support **with the**

verbiage specified in the Family Planning Agreement Addendum 151.

d. The committee must assure that the materials are suitable for the population and community for which they are intended.
e. Advisory Committee reviews informational and educational materials annually or as needed.
f. Family Planning media review documentation and summary of committee meetings using form DHHS 3491 are submitted annually and no later than **June 30, 2024** to the **Reproductive Health Branch via Smartsheet @ https://app.smartsheet.com/b/publish?EQBCT=82018408e7b44ef9b44e113b6e536ffb.**

2. Committee members will need to address the following issues as they review the material.

a. Consider the educational and cultural backgrounds of the individuals to whom the materials are addressed;
b. Consider the standards of the population or community to be served with respect to such materials;
c. Review the content of the material to assure that the information is factually correct, medically accurate, culturally and linguistically appropriate, and inclusive and trauma informed;
d. Determine whether the material is suitable for the population or community to which it is to be made available;
e. Establish a written record of its determinations; and
f. The factual, technical, and clinical accuracy of educational material will be completed by the clinic coordinator and/or medical provider as needed, Ex. Referring Spanish information to outside interpreter to review. However, final approval of the informational and educational material rests with the committee(s).

3. Community Participation, Education and Project Promotion.

a. The Advisory Committee for Community Engagement, Community Participation, Education and Project Promotion will consist of key agency program staff and may include the Family Planning coordinator, Director of Nursing, Medical Director and Health Education staff as well as other necessary staff.

- This committee will participate in the development, implementation, and evaluation of the Family Planning Program.
- The committee must also establish a plan for community participation.

b. The committee must collaborate annually or, more often as needed.

c. Community Education

- The Family Planning Project Committee must provide for community education programs. This should be based on an assessment of the needs of the community and should contain an implementation and evaluation strategy. For this reason, members comprising the committee should be representatives of all elements of our Family Planning population to be served, and should be individuals knowledgeable about the community's needs for Family Planning services.
- Community education should serve to enhance the communities understanding of the objectives of the services, make known the availability of services to potential clients, and encourage continued participation by persons to whom Family Planning may be beneficial.
- Project Promotion - To facilitate community awareness of and access to Family Planning services, the agency must establish and implement planned activities whereby their services are made known to the community. The agency should review a range of strategies and assess the availability of existing resources and materials. Promotion activities should be reviewed annually and be responsive to the changing needs of the community.
- An evaluation method should be used to assess community participation project promotion such as health fairs, Family Planning media review, and Information and Education Committee meetings.

E. Procedure

1. Client Education

a. All client education must be documented in the client's clinical record.

b. Education services **should be based on the following principles:**

- **Educational materials should be clear and easy to understand;**
- **Information should be delivered in a manner that is culturally and linguistically appropriate;**
- **The amount of information should be limited and emphasize essential points which focus on knowledge gaps identified during the assessment;**

- **Whenever possible, natural frequencies and common denominators (i.e., 1 in 100 using and IUD or implant is likely to get pregnant within 1 year, etc.) are used in education activity;**
- **Balanced information on risks and benefits of the contraceptive method chosen by the client or their partner should be presented and messages framed positively;**
- **Active patient engagement should be encouraged and each appointment should be tailored to the patient's individual circumstances and needs; and**
- **Information needed to make an informed decision about family planning must be provided.**

2. Counseling

   a. The primary purpose of counseling in the Family Planning setting is to assist clients in reaching an informed decision regarding their reproductive health and the choice and continued use of Family Planning methods and services. The counseling process is designed to help clients resolve uncertainty, ambivalence, and anxiety about reproductive issues and to enhance their capacity to arrive at a decision that reflects their considered self-interest.

   b. The counseling process involves mutual sharing of information. Persons who provide counseling should be knowledgeable, objective, nonjudgmental, sensitive to the rights and differences of clients as individuals, culturally aware and able to create an environment in which the client feels comfortable discussing personal information. The counselor must be sufficiently knowledgeable to provide accurate information regarding the benefits and risk, safety, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the various contraceptive methods. Additionally, the counselor should be knowledgeable about the other services offered by the agency. Documentation of counseling must be included in the client's electronic medical record.

   c. Method counseling refers to an individualized dialogue with a client that may cover the following:

      - Results of physical exam and lab studies;
      - Effective use of contraceptive methods, including natural family planning (NFP), and the benefit and efficacy of all contraceptive methods;
      - Possible side effects/complications;

- How to discontinue the method selected and information regarding back-up method use, including the use of certain oral contraceptives as post-coital emergency contraception;
- Planned return schedule;
- Emergency 24-hour telephone number;
- Location where emergency services can be obtained; and
- Appropriate referral for additional services as needed.

3. Sexually Transmitted Disease (STD) and HIV/AIDS Counseling

   All clients must receive thorough and accurate counseling on **STDs**. **STD counseling** refers to an individualized dialogue with a client in which there is discussion of personal risks for **STDs**, and the steps to be taken by the individual to reduce risk, if necessary. Persons found to have behaviors which currently put them at risk for **STD** must be given advice regarding risk reduction and must be advised whether clinical evaluation is indicated. Education includes instruction about **STD** risks and infection prevention, and referral services.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: SEXUAL ASSAULT PROTOCOL

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services does not provide services for clients of sexual assault. The protocol for disposition of sexual assault clients is to send all of these clients to the local emergency room(s) due to the necessity and requirement for a legal chain of custody regarding the clinical evidence collected following a sexual assault. Due to the fact that the Division of Public Health Services is not equipped to provide such a chain of custody, the clients cannot be evaluated.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NEXPLANON

DATE DEVELOPED: 3/07
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/20; 6/22; 6/24

I. POLICY:

Nexplanon will be inserted and removed only by an Advanced Practice Provider (APP) who has completed a clinical training program sponsored by **Organon**. Nexplanon will be made available, based on funding, to eligible Family Planning clients, including adolescents**,** requesting this method of contraception unless medically contraindicated. The Division of Public Health Services strives to provide long acting reversible contraceptives (LARCs) to help reduce unintended pregnancies and improve selected health practices among low-income families. By decreasing the number of unplanned pregnancies and the poor health outcomes associated with these pregnancies, the Division of Public Health is also reducing infant mortality and morbidity.

II. PURPOSE:

Nexplanon is a type of birth control for women. It is a **single, radiopaque, rod-shaped implant containing 68 mg of etonogestrel, a progestin hormone. The implant is** 4 cm x 2 mm and is inserted subdermally, typically in the inner aspect of the client's non-dominant upper arm. A single Nexplanon **implant** is effective pregnancy prevention with < 1 pregnancy per 100 women in a year (> 99% efficacy) for up to three years.

III. GUIDELINES:

A. Contraindications:

1. Known or suspected pregnancy
2. Thrombosis (current or past history of)/thromboembolitic disorders
3. Undiagnosed abnormal genital bleeding
4. Hepatic tumors (benign or malignant), active liver disease
5. Known or suspected carcinoma of the breast or personal history of breast cancer or other progestin-sensitive cancer now or in the past
6. Hypersensitivity to any of the components of Nexplanon.

B. Management:

1. Client should have a pregnancy test prior to insertion to rule out pregnancy.
2. Personal medical, immediate family medical, gynecological/ obstetrical, immunization status, sexual, social and mental health

history should be obtained prior to insertion. A physical assessment examination and a pap smear (if age 21 or greater) as indicated per current pap smear guidelines should be documented before Nexplanon insertion. (See FP-1 policy for physical assessment guidance.)

3. Ensure client understands the risks and benefits of Nexplanon before insertion.
4. Provide the client with:

    a. Copy of patient labeling included in packaging,
    b. User Card for client's records, and
    c. Personal menstrual calendar **as indicated** (with instructions for use).

5. Have the client complete a RCDHHS Division of Public Health Services consent form for insertion treatment and maintain it in the client's medical record.
6. Client has reviewed and completed the manufacturer's consent form to be maintained in the client's medical record. Client has also signed the electronic health record method specific consent form for Nexplanon.
7. Confirm the client has no allergies to the antiseptic and anesthetics to be used during insertion.

C. A Nexplanon device is initially inserted, an existing Nexplanon device is removed, or an existing Nexplanon device is removed with re-insertion of a new device by the APP. **For further guidance, side effects, or possible risks, full prescribing information is available per manufacturer's package insert and/or at https://www.organon.com.**

D. Follow-Up Requirements:

The APP documents the client's method in the client's medical record along with any pertinent clinical data. The client is given instructions on any required follow-up needed, advised how to report any problems or concerns with the method as well as insertion/removal site care and signs/symptoms to report. The client is assisted to schedule any follow-up needed or instructed to follow-up for annual preventive visit with evaluation/ management of the contraceptive method if no immediate follow-up is indicated.

Client is provided the Division of Public Health's Nexplanon insertion and/or removal instructions – English/Spanish fact sheet for reference (media review approved educational resource).

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: FAMILY PLANNING PROGRAM POLICY FOR TITLE X STAFF ORIENTATION AND TRAINING

DATE DEVELOPED: **3/17**
REVIEWED: **6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/18; 6/22; 6/24**

I. POLICY:

It is the policy of the RCDHHS-Division of Public Health Services to provide a comprehensive orientation for all staff working in the Title X program that is specific to the staff member's role when working with Title X clients, and to provide necessary training, one-time or on an annual basis, to assure continued understanding of program requirements.

II. PURPOSE:

This policy is intended to establish guidelines for the orientation and training of all Title X funded staff and staff who provide services to Title X clients.

III. DEFINITIONS:

None

IV. RESPONSIBILITIES:

This policy applies to all members of the RCDHHS-Division of Public Health Services workforce who work in the Title X program, including full-time, part-time, temporary paid employees and contractors under the direction of the Health Director.

V. GUIDELINES: REQUIRED TRAINING COURSES

It is the responsibility of the Health Director or their designee to have all Title X-funded staff and staff who provide services to Title X patients (e.g., management support, lab, social workers, health educators, clinicians/ providers/Medical Directors, nurses, and other staff) complete the following federal and state required training.

A. **One Time, on hire, Title X-funded staff and staff who provide services to Title X patients, or who oversee the provision of services to Title X patients are required to complete the *NC Title X Orientation Checklists.* The applicable Orientation Checklists must be completed within 60 days of hire.**

1) **Orientation Checklists can be assessed via Smartsheet dashboard.**
2) **The Orientation Checklists are in a Microsoft Excel workbook which contains tabbed sheets, and each sheet designates which types of staff must complete that sheet. All new staff must complete the tab labeled "All Staff Orientation." Other tabs are role-specific; new staff must complete the tab that matches their role in working with Title X patients.**
3) **Originals of initial orientation documents (i.e., All Staff Title X Orientation Checklist and Role-specific Checklists) must be on file in the employee's personnel file and retained in accordance with 2021 General Records Schedule, Standard 4, Items 4.28 and 4.41. Copies must be readily accessible and available for review by the WICWS Regional Nurse Consultant during monitoring.**

B. **All Title X-funded staff and staff who provide services or who oversee the provision of services to Title X patients are required to complete the trainings indicated on the NC Title X Family Planning Program Annual Training Record available on Smartsheet by May 31. This record must be signed by the Family Planning Medical Director and submitted no later than June 30 each year via Smartsheet.**

C. **Even if the Health Director position is not Title X-funded, DPH recommends the above training courses for the Local Health Director.**

Curriculum vitae of the Medical Director/Physician responsible for approving the Family Planning policies/procedures/protocols must indicate special training or experience in family planning if the Medical Director/Physician is not a board-certified OB-GYN. Medical Directors/Physicians who are not board-certified OB-GYHs are required to participate in training or continuing education related to Family Planning on an annual basis and are required to maintain documentation of their participation. The WICWS website has a list of possible trainings or continuing education opportunities.

- All clients seen in Public Health clinic programs will receive an electronic client satisfaction survey in the month following their individual encounter with request to evaluate care provided during their visit.
- Client satisfaction survey results will be tabulated monthly by designated staff and dispersed to clinical staff for review, including specific client comments, to assure staff knowledge of service delivery satisfaction.
- Administrative staff, including the Health Director, also review client satisfaction survey results. These results are also submitted to Rockingham County DHHS-Division of Public Health Board of Health

D. Family Planning clinical staff will receive training on:

- Providing services in accordance with recommendations for Quality Family Planning (QFP) Guidelines.
- Counseling minors on how to resist being coerced into engaging in sexual activities, repeated annually.
- Regarding encouraging family involvement in minor's decisions to seek Family Planning Services, repeated annually.
- Title X requirements for Pregnancy Counseling/Testing and recommendations presented in the QFP.
- Orientation to the 340-B drug dispensing program.
- Family Planning RN clinical staff will complete dispensing training with the RCDPH Pharmacist with documentation of training maintained in the staff education file and pharmacy.

E. Staff members will be responsible for retaining their completion certificates for specific courses to document the training content. Copies of staff completion certificates are also retained in individual staff training files and in Staff Development. Training may be provided in the context of a staff meeting. Staff meeting minutes and sign-in rosters for the staff meeting will constitute documentation of the training content, and will be maintained by Staff Development.

F. Annual review of the mandatory training documentation of all staff funded by Title X funds will be conducted by RCDHHS-Public Health Staff Development to assure compliance. The **Reproductive Health Branch of the Women, Infant, and Community Wellness Section (WICWS)** Regional Nurse Consultant and/or other NC Division of Public Health designee or Federal Title X staff may review at any time all or some of the training documentation in the staff educational files or staff development records to assure compliance.

VI. APPLICABLE LAWS, RULES AND REFERENCES:

- Program Requirements for Title X Funded Family Planning Projects (http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf)
- Providing Quality Family Planning Services MMWR (http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf)
- NCHHS **Reproductive** Health Branch **of the WICWS** Family Planning Staff Title X Orientation and Annual Trainings and Checklists http://whb.ncpublichealth.com/provPart/training.htm
- **https//app.smartsheet.com/b/publish?EQBCT=82018408e7b44ef9b44e113b6e536ffb**

VII. REFERENCE POLICIES:

1. RCDHHS-Public Health Family Planning Title X Funding Policy (FP-13)
2. RCDHHS-Public Health Nursing Services Abuse/Neglect and Human Trafficking (NUR-13)
3. RCDHHS-Public Health Nursing Services Competency Verification (NUR-9)

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: FERTILITY-AWARENESS BASED BIRTH CONTROL METHODS

DATE DEVELOPED: 05/2022
REVIEWED: 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services will offer Fertility-Awareness Based Methods (FABMs) contraceptive to eligible Family Planning clients, including adolescents, for prevention of pregnancy or pregnancy planning. FABMs will be available to all eligible clients choosing this contraception method as medically appropriate.

II. PURPOSE:

This policy is intended to establish guidelines for providing Fertility-Awareness Based Methods as a form of contraception for female Family Planning clients desiring this method of pregnancy prevention or pregnancy planning.

III. GUIDELINES:

A. Eligibility:

See Family Planning Policy-1 for Family Planning eligibility determination guidelines.

B. Indication and Usage:

Fertility-awareness based methods (FABMs) help couples understand how to avoid pregnancy or how to become pregnant by teaching them to predict high fertility and low fertility days. FABMs can address preferences of clients to use a method that has no side effects, can be used together with their partners, and can be used to avoid or achieve pregnancy.

FABMs rely on five biologic facts:

1. The periodicity of fertility and infertility that occurs during each menstrual cycle;
2. A single ovulatory event each cycle
3. The limited lifespan of the ovum (which can be fertilized only in the short time span of 12-24 hours after release);

4. The limited lifespan of sperm in cervical mucus and the upper genital tract (3-5 days);
5. The ability of a person using FABM to monitor cycle length or cycle-related symptoms and signs.

FABMs may simply involve keeping track of cycle days to understand which days of the menstrual cycle are most likely to be fertile. Other FABMs involve observing, recording, and interpreting the body's fertility signs. Effectiveness of FABMs average 75-95 % effectiveness and vary dependent on:

- The accuracy of the method in identifying the actual fertile window,
- The ability of the person using the method to correctly interpret the information to identify the fertile window, and
- The ability of the couple to follow the instructions of the method-that is, to use a barrier method or avoid vaginal intercourse on the days the method identifies as fertile.

C. Considerations:

1. <u>Standard Days Method (SDM)</u>

   - This method, based on fertility awareness, requires the client to avoid unprotected sexual intercourse on days 8-19 of the menstrual cycle for pregnancy prevention.
   - This method is reversible and can be used by women of all ages.
   - This method does not protect against risk for STDs, including HIV.
   - Women with menstrual cycles of 26-32 days may use this method.
   - Clients must provide a barrier method of contraception for protection on days 8-19.
   - If the client has unprotected sexual intercourse during days 8-19, consider the use of Emergency Contraception if appropriate.
   - To promote pregnancy, couples should try to have intercourse between day 8-19, either every day or every other day.
   - Women with two or more cycles of <26 or >32 days within any 1 year of SDM use must be advised that the method might not be appropriate because of a higher risk of pregnancy.

2. <u>Temperature Method</u>

   - Basal body temperature (BBT) is the body temperature when you are fully at rest. In most women, the body's normal temperature increases slightly during ovulation (0.5-1°F) and remains high until the end of the menstrual cycle.

- This method requires the client, before getting out of bed, take their temperature by mouth with a basal thermometer and watch for their temperature to increase.
- When client temperature rises a little on a basal thermometer, it is a sign that an ovary has released an egg.
- The most fertile days are the 2-3 days before this increase in temperature. BBT shows only when ovulation has already occurred, not when it is going to occur.
- Women who have a hard time remembering to take their temperature may not be successful with this method.
- Clients who get an infection or are sick may have altered temperature, making this method unreliable.

3. Calendar Method

- This method requires the client to use the calendar to figure out when an ovary releases an egg.
- Most clients will release an egg, or ovulate, about two (2) weeks before their period.
- Women who have a hard time remembering to keep a record on the calendar may not have success with this method.

4. Mucus Method

- This method requires the client to check the mucus from their vagina, or birth canal.
- This method involves recognizing changes in the mucus produced by the cervix and in how the mucus looks and feels.
- Just before ovulation, the amount of mucus made by the cervix noticeably increases, and the mucus becomes thin and slippery, then an egg is likely to be released.
- Just after ovulation, the amount of mucus decreases, and it becomes thicker and less noticeable.
- To prevent pregnancy, clients should avoid sexual intercourse or use a barrier method of birth control from the time cervical mucus is first noticed.
- To promote pregnancy, clients should have intercourse every day or every other day when the thin and slippery cervical mucus is present.
- Women who have a hard time remembering to check their mucus every day may not be successful with this method.
- When clients get an infection or are sick, these conditions may cause mucus to change resulting in inaccurate signs and method failure.
- Any changes in health or daily routine that could make reading the signs of ovulation difficult: medications, feminine hygiene products, douching, breastfeeding, sexual intercourse or having a

pelvic exam in which lubrication is used can change cervical mucus.

D. Disadvantages and Cautions

FABMs lead to higher typical use pregnancy rates than for hormonal birth control methods. FABMs produce no physical side effects but offer no protection against sexually transmitted infections, including HIV. Lack of partner cooperation may pose an obstacle for females who wish to practice abstinence or use an alternative method during the fertile time. Conditions that increase likelihood of irregular cycles may make FABMs more difficult to use and clients with these conditions require more extensive counseling and follow-up:

- Recent childbirth
- Current breastfeeding
- Recent menarche
- Anovulatory cycling as with PCOS or obesity-related infrequent cycles
- Recent discontinuation of hormonal contraceptive methods
- Approaching menopause

G. Method:

Specific consent form signed by client for Fertility-Awareness Based Method.

H. Clinical Record:

Documentation in the client's medical record of the specific FABM client chosen contraceptive method along with education and counseling provided.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TRANSDERMAL (BIRTH CONTROL) CONTRACEPTIVE PATCH

DATE DEVELOPED: 5/2022
REVIEWED: 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services may provide the birth control patch to eligible Family Planning clients, including adolescents. The birth control patch is indicated for the prevention of pregnancy, and will be made available by written prescription for all eligible clients choosing this birth control method. A prescription will be provided to the client's pharmacy of choice.

II. PURPOSE:

This method of birth control is prescribed to female clients with a BMI < 30kg/m² for prevention of pregnancy. The type of contraceptive patch prescribed for a client will be determined by the Advanced Practice provider. Changes in prescription will be made by the Advanced Practice provider, if needed, due to side effects or problems with the birth control patch.

III. GUIDELINES:

A. Eligibility:

See Family Planning Policy-1 for Family Planning eligibility determination guidelines.

B. Indication and usage:

The birth control patch is a type of contraception that contains the hormones estrogen and progestin. The birth control patch works similarly to combination birth control pills by releasing hormones that prevent ovulation. The birth control patch also thickens cervical mucus to prevent sperm from reaching an egg. The birth control patch is used in a 4-week cycle with each of the three patches applied and worn for 7 days. Three patches are worn for three weeks total (21 consecutive days). When the third patch is removed after 7 days, a patch-free fourth week begins before the 4-week cycle repeats. The patch free fourth week allows a hormone withdrawal bleed/menstrual cycle. The birth control patch effectively prevents pregnancy in 92-97% of users; it does not prevent sexually transmitted diseases including HIV.

Body weight is associated with lower hormone levels in birth control patch users. Studies suggest the birth control patch may be less effective in women weighing more than 90 kg (198 lb) with higher risk of pregnancy when using this method.

This method of birth control may be more desirable for clients:

1. Who have problems complying with daily pill regimens
2. Who want a short acting and/or noninvasive option
3. Who are experiencing significant side effects with other methods,
4. Who have medical conditions contraindicating the use of other methods.

C. Prescribing the birth control patch:

a. The Advanced Practice provider may prescribe a full year of birth control patch to a new client initiating this birth control method, as well as to clients with prior experience in use of the birth control patch, based on the individual client's evaluation and assessed understanding of use of the birth control patch.
b. New Family Planning clients desiring the birth control patch who are determined to need further evaluation of appropriate use may be given a limited prescription by the Advanced Practice provider at the first visit based on individual client evaluation/assessment.
c. Clients given an initial limited prescription of the birth control patch will be instructed to return before supply runs out, when indicated for medical evaluation of the method. If there are no contraindicating factors, the client will be given remaining prescription of her original prescription to complete a 1-year order.
d. Clients continuing the birth control patch at the second annual examination will be prescribed a full year of the birth control patch unless contraindicated based on client evaluation and assessed understanding of use.
e. Clients who are using the birth control patch should have annual preventive visits.

D. Initiation of birth control patch:

<u>First Day start:</u>

1. Client should apply her first patch during the first 24 hours of her Menstrual period. If a patch is applied after the first 24 hours of Menstruation, non-hormonal back-up contraception (such as condoms and spermicide) is needed for the first 7 days of the first cycle only.

2. Client should apply a new patch each week for three weeks. Every new patch should be applied on the same day of the week. This day is known as the "patch change day". Only one patch should be worn at a time. The patch can be applied to the buttocks, back, upper outer arm, lower abdomen, or upper torso (excluding the breasts). The patch should not be cut, damaged, altered in any way as efficacy may be impaired. Under no circumstances should there be more than a 7-day patch-free interval between dosing cycles.

Sunday start:

1. Client should apply her first patch on the first Sunday after her menstrual period begins.
2. With this option, a non-hormonal method of birth control, such as condom and spermicide, is needed for the first 7 days of the first cycle only.
3. If the period starts on a Sunday, the first patch should be applied that day, and no backup contraception is needed.

E. Medical Conditions Contraindicating Combined Contraceptive Use including the birth control patch:

1. Thrombophlebitis or thromboembolic disorders (or history thereof)
2. Cerebrovascular disorders (or history thereof)
3. Ischemic heart disease or coronary artery disease (or history thereof)
4. Valvular heart disease with complications
5. Hypertension uncontrolled
6. Diabetes with vascular involvement
7. Headaches with focal neurological symptoms (migraines with aura) (Women over age 35 with any migraine headaches)
8. Carcinoma of the endometrium
9. Undiagnosed abnormal uterine bleeding
10. Inherited or acquired hyper-coagulopathies
11. Body Mass Index $\geq$30kg/m^2
12. Hypersensitivity to any component of the product
13. Major surgery with prolonged immobilization
14. Known or suspected carcinoma of the breast (or history thereof)
15. Known or suspected estrogen-dependent neoplasia (or history thereof)
16. Pregnancy, known or suspected
17. Benign or malignant liver tumor (hepatic adenomas) (or history thereof) or liver disease
18. Age 35 and > and smoker for combined contraceptives

19. Use Hepatitis C drug combinations containing ombitasvir/paripaprevir/ritonavir with or without dasabuvir (potential for ALT elevations)

F. Side Effects:

Hormones from the birth control patch enter the blood stream and are processed by the body differently than hormones from birth control pills. Clients are exposed to about 60% more estrogen than if using a typical birth control pill containing 35 mcg of estrogen. Increased estrogen may increase risk of side effects. If client reports complaint of side effects, the Advanced Practice Provider should evaluate the client and a decision should be made about continuing with the method or need for switching to another method.

**Note-Complaint of severe pain or pressure in the chest; sudden, severe headache unlike usual headaches; sudden shortness of breath; sudden blindness, partial or complete; leg pain that will not go away; weakness or numbness in an arm or leg, or trouble speaking; yellowing of the skin or eyeball should be reported to the Advanced Practice Provider immediately upon evaluation.

The most common side effects of the birth control patch include:

1. Breast symptoms (discomfort, swelling, or pain)
2. Nausea
3. Headache
4. Skin irritation, redness, pain, swelling, itching or rash at the patch application site
5. Stomach pain
6. Pain during menstruation
7. Vaginal bleeding and menstrual disorders, such as spotting or bleeding between periods
8. Mood, affect and anxiety disorders

Less common side effects include:

1. Acne
2. Less sexual desire
3. Bloating or fluid retention
4. Blotchy darkening of the skin, especially the face
5. High blood sugar, especially in women with diabetes
6. High fat (cholesterol, triglyceride) levels in the blood
7. Depression, especially if the client had depression in the past (any reported thoughts of self-harm requires immediate intervention)
8. Problems tolerating contact lenses
9. Weight gain

G. Method:

Specific consent form signed by client for Estrogen Containing Contraceptive (combined contraceptive patch).

H. Clinical Record:

Documentation in client's medical record of the prescription for birth control patch as the client's method of birth control.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

HEALTH EDUCATION POLICIES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ORIENTATION OF HEALTH EDUCATION SECTION

DATE DEVELOPED: 5/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/24

I. POLICY:

The Division of Public Health Services will provide Health Education services to clients, staff, and community.

II. PURPOSE:

The purpose of the Health Education Section is to assess the needs of the community and plan appropriate programs according to scientific, peer reviewed information gathered.

III. GUIDELINES:

A. The hours of operation are 8:00 am – 5:00 pm Monday – Friday except for county holidays and county closings (inclement weather days, etc.). Occasional extended hours may be required after 5:00 pm daily or on the weekends for presentations**,** health fairs**,** and/or work demands.

B. Health education services are provided for health department programs, community partners, and the community members/residents.

C. The Health Education staff will communicate wellness and health education needs, concerns and resources through:

1. Evaluating health education programs.

2. Understanding and implementing the responsibilities of the health education program.

3. Analyzing the foundations of health education.

4. Investigating and applying strategies regarding social determinants and affecting factors which opposes viewpoints related to health education needs and concerns

5. Selecting appropriate communication methods and techniques in providing health information.

6. Demonstrating proficiency in communicating health information and health education needs.

D. The Health Education Staff will act as a resource person in health education through:

1. Utilizing scientific health information, and retrieving appropriate data systems and other resources to prepare health education needs.

2. Establishing effective collaborative relationships with those requesting assistance in solving health related problems. This may be achieved by:

   a. analyzing parameters of effective and appropriate collaborative relationships
   b. describing special skills and abilities needed by health educators
   c. formulating a plan for providing collaborative efforts with other health professionals
   d. explaining the process of marketing appropriate health education services

3. Interpreting and responding to requests for health information.

   a. Employing a variety of appropriate resources when identifying, analyzing, and providing health information
   b. Selecting information designed per individual request

4. Selecting effective educational resources materials for dissemination.

   a. assembling educational material of value to individuals and community groups
   b. evaluating the worth and applicability of resource materials for audiences
   c. comparing different methods for distributing educational materials

E. The Health Education program staff will collaborate with the nursing staff in assisting with community events or health fairs.

F. The Health Education program staff will make referrals to clinical services as indicated.

G. The Health Education staff will be knowledgeable about the health department services offered.

H. Improving Organization Performance

1. State and local reports and statistics are reviewed with management team at least annually to determine if the needs of the community are being met and to identify any changes indicated.

2. **Competency checklists** will be **reviewed with** staff members **upon hire** and annually during the time of the performance evaluation.

3. Satisfaction Surveys and/or program or presentation evaluations will be completed annually or as applicable and **summarized** results will be shared with the staff. A plan of corrective action will be established and implemented to improve any weaknesses.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ASSESSING INDIVIDUAL AND COMMUNITY ASSETS AND NEEDS FOR HEALTH EDUCATION

DATE DEVELOPED: 4/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16

I. POLICY:

The Division of Public Health Services, Health Education Section will conduct an assets and needs assessment on identified populations before planning programs to determine whether a health education program is justified, evidence-based and what the nature and emphasis should be.

II. PURPOSE:

The primary purpose of a needs assessment is to gather information to determine which, if any, health education initiatives are appropriate in a given setting. Needs assessment is the systematic, planned collection of information about the health knowledge, perceptions, attitudes, motivation and health practices of individuals or groups and the quality of the socioeconomic environment in which they live. Assessing need logically precedes program planning.

The primary purpose of identifying assets is to build capacity within an individual and/or community. Rather than identifying only what individuals and/or communities do not have (needs), identifying assets allows the health educator to learn what individuals and/or communities do have and assist them in building capacity based on those assets and resources.

III. GUIDELINES:

To conduct a thorough assets and needs assessment, the health educator should:

A. Obtain scientific health-related data regarding physical health (mortality and morbidity), as well as social determinants which impact a community.

1. Select reputable resources of information about health needs and information.

2. Use appropriate resources of health-related information.

3. Employ appropriate data-gathering resources.

4. Apply survey techniques to acquire health data.

B. Distinguish between behaviors that foster and those that hinder well-being.

1. Investigate physical, social, emotional, and intellectual factors influencing health behaviors.

2. Identify behaviors that tend to promote or compromise health.

3. Recognize the role of learning and effective experiences in shaping patterns of health behavior.

C. Implement strategies for the need of effective health education on the basis of obtained data and population served.

1. Analyze assets and needs assessment data.

2. Identify priority areas of need for health education services.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PLANNING EFFECTIVE HEALTH EDUCATION PROGRAMS

DATE DEVELOPED: 6/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The Division of Public Health Services, Health Education Section will plan health education programs based on data gathered from assets and needs assessment on general and targeted populations for all health education programs.

II. PURPOSE:

The primary purpose of planning health education programs is to ensure successful and effective program interventions.

III. GUIDELINES:

To plan an effective health education program, the health educator should:

A. Plan the Process.

1. Provide baseline data
2. State the goal of the planning process.
3. List in sequence all the steps or activities needed to accomplish the goal.
4. Develop a timetable.

B. Recruit community organizations, partners, and potential participants for support and assistance in program planning.

1. Communicate the need for the program to those whose support will be essential.
2. Obtain commitments from personnel and decision makers who will be involved in the program.
3. Seek ideas and opinions of those who will affect or be affected by the program.
4. Incorporate feasible ideas and recommendations into the planning process.

C. Plan with Data.

- Use the information gathered from the assets and needs assessment.

D. Develop a logical scope and sequence plan for a health education program.

1. Engage in long-range planning.
2. Prioritize health needs and opportunities.

E. Create SMART objectives, goals and action steps.

1. Goals should be broad statements that are not directly measurable, but are attainable. A goal lacks a deadline and is usually long-range.
2. Objectives directly address the completion of the program and should be the partial accomplishment of a goal. Objectives should be SMART:

    a. Specific
    b. Measurable
    c. Attainable
    d. Realistic
    e. Timely

3. If objectives need to be broken down into more manageable steps, action steps may be developed. Action steps outline highly specified activities, the person responsible, and a deadline for completion.

F. Plan for Evaluation

Evaluation should be built into program design. Recruiting the appropriate individuals to be part of the planning process, obtaining the necessary data for planning, creating goals and objectives, measuring goals and objectives and determining what data should be gathered should all be evaluated in this continuous process (see Policy HE-5 for more detail).

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: IMPLEMENTING HEALTH EDUCATION PROGRAMS

DATE DEVELOPED: 2/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The health educator will exhibit competence in carrying out planned educational programs through the Division of Public Health Services in conjunction (when applicable) with community partners and members.

II. PURPOSE:

To establish guidelines in which the health education program at the Rockingham County Division of Public Health can practice by in order to meet the community's needs.

III. GUIDELINES:

A. The following competencies will be ensured when delivering and implementing health educational programs:

1. Implement a variety of educational methods and techniques.

2. Apply individual and/or group process methods as appropriate to given learning situations and target populations.

3. Utilize appropriate equipment and other instructional media.

4. Select methods that best facilitate practice of program objectives.

B. Infer enabling objectives as needed to implement instructional programs in specified settings by:

1. Conducting pre-testing and post-testing to assess initial and final efficacies relevant to knowledge gained regarding program objectives.

2. Developing measurable and attainable objectives as needed for instructional use.

C. Select methods and media best suited to implement program goals/objectives by:

1. Analyzing the participants' characteristics, social norms feasibility that would influence choices among methods.

2. Evaluating the efficiency of alternative methods and techniques capable of effectively facilitating the program objectives.

3. Determining the availability of information, personnel, time, and other resources needed to implement the program effectively.

D. Monitor the educational programs, making changes or revisions as necessary by:

1. Comparing program activities to the planned and stated objectives.

2. Assessing the relevance of the existing program objectives to current needs.

3. Monitoring and revising the program activities and objectives as needed for participants' success.

4. Appraising applicability of resources and materials relative to given educational objectives.

rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EVALUATING THE EFFECTIVENESS OF HEALTH EDUCATION PROGRAM

DATE DEVELOPED: 5/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services, Health Education Section will evaluate the health education programs – comparing to the effectiveness of meeting the needs and objectives as outlined as they pertain to the identifiable population at hand.

II. PURPOSE:

To assess the effectiveness of educational services provided based on meeting the needs of the individuals and the community as a whole.

III. GUIDELINES:

A. The health educator should develop plans to assess completion and achievement of the identified program objectives.

1. Determine standards of performance.

2. Establish a realistic scope of evaluation efforts.

3. Develop an inventory of existing valid and reliable tests and survey instruments.

4. Select appropriate methods for evaluating program effectiveness.

B. The health educator should carry out evaluation plans.

1. Facilitate administration of the tests and activities specified in the plan.

2. Utilize data collecting methods appropriate to meet the objectives.

3. Analyze resulting evaluation data.

C. The health educator should interpret results of the program evaluations.

1. Apply criteria of effectiveness to obtained results of a program.

2. Translate evaluation results into terms easily understood by others.

3. Report effectiveness of educational programs in achieving proposed objectives.

D. The health educator should infer implications from findings for future program planning.

1. Explore possible explanations for important evaluation findings.

2. Recommend strategies for implementing results of evaluation.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COORDINATING PROVISION OF HEALTH EDUCATION SERVICES

DATE DEVELOPED: 05/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The Division of Public Health Services, Health Education Section will develop a plan for coordinating health education services.

II. PURPOSE:

To determine the extent of available health education services, and match those services to proposed program activities as needed.

III. GUIDELINES:

A. The health educator will facilitate collaboration among levels of program personnel.

1. Promote cooperation and feedback among personnel related to the program implementation and outcomes.

2. Apply various methods of conflict resolution as needed.

3. Analyze the role of health educator as liaison between program staff and outside groups and organizations.

B. The health educator will formulate practical modes of collaboration among health agencies and organizations.

1. Stimulate cooperation among personnel responsible for community health education programs.

2. Suggest approaches for integrating health education within existing health programs.

3. Develop plans for promoting collaborative efforts among health agencies and organizations with mutual interests.

C. The health educator will organize and/or assist with the organization of in-service training:

1. Plan an operational, competency-oriented training program.

2. Utilize instructional resources that meet a variety of in-service training needs.

3. Demonstrate a wide range of strategies for conducting in-service training programs.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: GRANT WRITING

DATE DEVELOPED: 08/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23: 6/24
REVISED: 6/20; 6/24

I. POLICY:

The Division of Public Health Services, Health Education Section will continuously seek outside funding through the development of professionally written grant proposals.

II. PURPOSE:

To assist with the selection and writing of all grant proposals. To ensure grants that are submitted have been prepared in accordance with the most competitive standards.

III. GUIDELINES:

A. DEFINITION of a grant is a monetary **or material** award **given** to carry out a community project or to fund a position.

B. ASSESSMENT

1. To assess if a grant **application in an appropriate use of staff resources**, the following should be applicable:

- A new project or the expansion of an existing project with additional financial costs are involved
- These costs will not be covered in the current budget
- A granting agency has been identified that makes awards to pay for the types of costs **or to provide the types of resources** needed for the project
- The project will meet the eligibility standards for such awards
- Appropriate personnel will be able to commit the needed time and energy to the grant-writing process.

C. APPLYING FOR A GRANT

1. **Staff will** determine the best grant source for the project. There are three main sources for grants.

a. Government
b. Private businesses and corporations
c. Foundations

2. **Staff will** research the grant source selected. To ensure **that the grant opportunity aligns with current goals and objectives, staff will:**

   a. Check the fields to which the grant is offered.
   b. Check the purpose of grant offered.
   c. Check the **scope** of grant offered.
   d. Check the **geographic** locations where grant is offered.

3. **Staff will read the Request for Proposal (RFP)/Request for Applications (RFA) and follow the rules and instructions**.

4. **Staff will** allow enough time to prepare a competitive **application, and** become familiar with the common elements in a grant proposal:

   a. Cover letter, title page, and abstract
   b. Statement of the Problem/Needs Statement
   c. Project Description (goals and objectives and methods/activities)
   d. Evaluation Plan
   e. Budget Request and Budget Justification
   f. Applicant Qualifications
   g. Future Funding Plans/Plans for Sustainability
   h. Appendices (As needed and/or requested)
      - A marketing or dissemination plan schematic
      - A project staffing flow chart
      - A time line chart of proposed activities
      - An evaluation instrument (e.g., a survey that will be used)
      - Any existing educational or printed materials to be used
      - Bio-sketches or curriculum vitae of key project personnel, including Advisory Board members and any consultants already identified
      - Letters of Support/Participation

5. **Staff will include features of a strong proposal in their grant applications, including**:

   a. Well-organized proposal sections
   b. Well-researched and documented statement of the problem
   c. Creative or innovative strategies for addressing the need/problem

d. Feasible goals and objectives
e. Measurable objectives
f. A comprehensive evaluation plan

6. PROCESS:

a. **Staff members will** submit any proposal idea(s) to the Health Education Program Manager, who will review them with the Health Director.
b. Upon the Health Director's approval, the **staff member(s)** should then **prepare** the grant proposal application.
c. Prior to submission, the grant application will be reviewed and approved by the Health Education Program Manager and the Health Director.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CULTURAL COMPETENCY

DATE DEVELOPED: 08/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services, Health Education Section will strive to assure that agency staff is culturally competent in all aspects of public health, including communication, translation, delivery of care, treatment, and the development of all health education materials and media.

II. PURPOSE:

To define cultural competency, identify the components that make up cultural competency, and to ensure that steps are taken to maintain cultural competency at the Division of Public Health. To ensure that all employees are effectively communicating with and being respectful of those different from one's own race, gender, and cultural beliefs.

III. GUIDELINES:

A. Culture is defined as the shared traditions, beliefs, customs, history, folklore, and institutions of a group of people. Culture is shared by people of the same ethnicity, language, nationality, or religion. It's a system of rules that are the bases of what we are and affect how we express ourselves as part of a group and as individuals.

B. Organizations have a "culture" of policies, procedures, programs, and processes, and incorporate certain values, beliefs, assumptions, and customs. Organizational cultures largely echo mainstream culture in its sense of time orientation, perception, and use of time. An organizational culture may not lend itself to cultural competence, so that's where skill building comes in. A culturally competent organization brings together knowledge about different groups of people and transforms it into standards, policies, and practices that make everything work.

C. There are four stages to cultural competency:

1. Cultural knowledge means that you know about some cultural characteristics, history, values, beliefs, and behaviors of another ethnic or cultural group.

2. Cultural awareness is being open to the idea of changing cultural attitudes.

3. Cultural sensitivity is personal acknowledgement that differences exist between cultures, but not assigning values to the differences.

4. Cultural competence brings together the previous stages and adds operational effectiveness. A culturally competent organization has the capacity to bring into its system many different behaviors, attitudes, and policies and work effectively in cross-cultural settings to produce better outcomes.

D. An organization has all types of diversity. However, some types of diversity have a larger impact on organizations than others because they have historical significance. These types of diversity are associated with a history of inequity and injustice where not every person or group has been treated equally because of them. These types of diversity include, but are not limited to:

1. Ethnicity
2. Gender
3. Sexual orientation
4. Social class
5. Spiritual beliefs and practices
6. Physical and mental ability
7. Age
8. Language
9. Education
10. Family status
11. Health status
12. Style
13. Skills and talents
14. Customs
15. Ideas
16. Military experience
17. National, regional, or other geographical area
18. Ownership of property
19. Work experience
20. Socioeconomic status

E. The Division of Public Health Services will strive to ensure that cultural competency is maintained in the workplace by:

1. Recognizing the power and influence of culture

2. Understanding how each of our backgrounds affects our responses to others

3. Not assuming that all members of cultural groups share the same beliefs and practices

4. Acknowledging how past experiences affect present interactions

5. Building on the strengths and resources of each culture in an organization

6. Allocating resources for leadership and staff development in the area of cultural awareness, sensitivity, and understanding

7. Actively eliminating prejudice in policies and practices

8. Willing to share power among leaders of different cultural backgrounds

9. Evaluating the organization's cultural competence on a regular basis

F. All staff will review this policy upon employment and again annually at the staff mandatory training(s).

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ROCKINGHAM COUNTY COMMUNITY HEALTH ASSESSMENT

DATE DEVELOPED: 3/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/20

I. POLICY:

The Division of Public Health Services, Health Education Section will conduct a comprehensive Community Health Assessment (CHA) in conjunction with NC Department of Health and Human Services, Division of Public Health every 4 years. The process will be directed by the Health Education Program Manager with facilitation from the Healthy Carolinians Coordinator. The CHA will be conducted in years preceding health department accreditation. During years in which the CHA is conducted, the CHA document is due in the Office of Healthy Carolinians/Health Education the 1st Monday of December. The information will be submitted electronically.

During the three interim years, the health department will issue a State-of-the-County Health Report (SOTCH) that will provide updated information about priority health issues specific to Rockingham County.

II. PURPOSE:

A CHA is a process by which community members gain an understanding of the health, concerns, and healthcare systems of the community by identifying, collecting, analyzing and disseminating information on community assets, strengths, resources, and needs. A Community Health Assessment usually culminates in a report or a presentation that includes information about the health of the community as it is today and about the community's capacity to improve the lives of residents. A Community Health Assessment can provide the basis for discussion and action.

The purpose of the assessment is to help the Rockingham County Community:

- Identify priority health issues and populations at risk,
- Identify priority populations based on the demographic profile,
- Identify community is available and needed resources and use of methodology to collect and analyze data,
- Develop a Community Health Implementation Plan (CHIP) to address the identified concerns,

- Obtain information and input through community collaboration from residents, community agencies and community stakeholders and report the results back to the community,
- Describe the socioeconomic, educational and environmental factors that affect the health of our residents,
- Assemble and analyze primary, secondary, and trend data to describe the health status of our community, and
- Generate and compare Rockingham County data to peer counties and state data.

III. GUIDELINES:

A. There are eight phases to a comprehensive CHA. They include:

1. Establish a Community Assessment Team
2. Collect Data From Our Community
3. Analyze the County Health Data Book
4. Combine Rockingham's Health Statistics with Our Community Data
5. Report to the Community
6. Select Health Priorities
7. Create a Community Health Assessment Document
8. Create the Community Health Implementation Plan

B. CHA is a collaborative process and is done *by* the community rather than *on* the community. Therefore, we will include community partners throughout the process in order to keep members updated.

C. The completion of the CHA is made possible by the contribution of many agencies, churches, community groups, healthcare professionals, and citizens of Rockingham County. Contributors are listed within each CHA.

D. A copy of the final results of the Rockingham County Community Health Assessment are published and disseminated throughout the county. The results can also be obtained via the agency websites:

http://www.rockinghamcountypublichealth.org
http://www.rockinghamcountydhhs.org

A detailed description of conducting a CHA is included in the Community Health Assessment Guide Book located in the Health Education Program Manager's office.

Further questions may be addressed by contacting:

Kathryn G. Dail, PhD, RN
Branch Head, Local Data Analysis Support

Director, Community Health Assessment and HNC 2030
Division of Public Health
State Center for Health Statistics
NC Department of Health and Human Services
1916 Mail Service Center
Raleigh, NC 27699-1916

Office: 919-707-5196
Mobile: 919-500-8937
Fax: 919-870-4833
kathy.dail@dhhs.nc.gov

or

Beth Murray
NC Department of Health and Human Services
Administrative Assistant, Local Technical Assistance and Training Branch
Division of Public Health
1916 Mail Service Center
Raleigh, NC 27699-1916

Phone: (919) 707-5132
Fax: (919) 870-4833
beth.murray@dhhs.nc.gov

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ROCKINGHAM COUNTY STATE OF THE COUNTY HEALTH REPORT

DATE DEVELOPED: 5/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/20; 6/24

I. POLICY:

The Division of Public Health Services, Health Education Section will prepare data and complete an annual State of the County Health Report (SOTCH).

II. PURPOSE:

This report is designed to promote a broader understanding of the health of our community and measure local progress in improving the health of our community through collaboration with community partners.

III. GUIDELINES:

A. This brief document will provide data and key indicators of our community's health and well being, comparing Rockingham County, North Carolina and The NC **2030** Health Objectives. During the three interim years of the community health assessment, the Health Department will issue a State of the County Health Report that will provide updated information about priority health issues specific to Rockingham County.

B. This report provides information on priorities our community identifies in the Community Health Assessment, such as; focusing on chronic illness, lifestyle behaviors, education, substance abuse, and mental health as well as other identified health indicators.

C. This report highlights areas such as public policy, community based initiatives, and resources needed to create a healthier future.

D. This report is presented by **members of the Health Education Section.**

E. The community collaboration will establish priority areas to address, health issues that were identified in the current Community Health Assessment. Priority issues will be prioritized annually through the SOTCH Report.

F. The State of the County Health Report is made available to all persons who request a copy. The SOTCH will be disseminated to all community

partners and agencies where community members will have access to its information. The SOTCH Report will also be displayed on the Rockingham County Department of Health and Human Services website at: http://www.rockinghamcounty.dhhs.org.

G. The Division of Public Health Services prepares a monthly activity report and annual reports prepared by the Health Education Program Manager. These reports identify the services rendered through the various programs of the health department. This report is disseminated to the County Manager, all Health Department Program Supervisors, the Health Director, the Board of Health and Human Services, and anyone who requests it.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: STUDENT HEALTH CENTERS

DATE DEVELOPED: 10/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/20; 6/24

I. POLICY:

The Division of Public Health Services and Rockingham County Student Health Centers entered an agreement. This agreement provides in-kind Health Education services to the Student Health Centers. There are four (4) Student Health Centers in Rockingham County Schools. This program provides easy access to comprehensive Healthcare Services to the high school students of Rockingham County.

II. PURPOSE:

The primary goal of the Student Health Centers is to reduce health risks for the students of Rockingham County through education, prevention, treatment, and referral.

III. GUIDELINES:

A. Promote a healthy lifestyle to encourage behavioral change.

1. Conduct one-on-one educational consultation sessions with high school students in a clinical setting.
2. Nutrition/Weight Management – educate and increase knowledge of healthy food choices.

- Benefits of Exercise
- Importance of Water
- Reading Food Labels

B. Increase knowledge **and understanding of healthful behaviors versus risky behaviors** through the following:

1. Classroom presentations - Teen Pregnancy/STI Prevention, Stress, and other health topics requested by teachers.
2. Disseminate information - Referrals/Access to healthcare at the health department.
3. Evidence-based health initiatives **related to Tobacco Use Prevention/Cessation, Alcohol & Drug Misuse, Peer Pressure, Healthy Relationships, etc.**

C. Charting of notes in student records and maintaining a schedule for student appointments, which includes providing a complete encounter log with ICD9 codes.

D. Disseminate information:

1. Prepare and compose newsletter for parents and students.
2. Research and stay current on information to be disseminated.

E. Annual Physicals:

Assist with annual athletic physical exam clinics held at each high school, **as requested**.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MEDIA AND COMMUNICATION

DATE DEVELOPED: 10/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/20; 6/24

I. POLICY:

A. All written media/communication originating from the health department shall be reviewed internally prior to dissemination to the public.

B. All press releases for Communicable Disease/Bioterrorism/Natural Disaster will be developed in collaboration with Health Director prior to dissemination.

C. The State Public Information Office will supply the Division of Public Health Services with the necessary press release information to be disseminated.

D. The Division of Public Health Services shall reflect the cultural and linguistic character of Rockingham County as required by Title VI of the Civil Rights Act and the Americans with Disabilities Act (ADA).

II. PURPOSE:

To ensure that the public receives the highest quality and most accurate communication from the Division of Public Health Services in order to promote public understanding of health programs and issues.

To preserve the Agency name within the community as a reliable source of information.

To ensure compliance with Title VI of the Civil Rights Act of 1964 with respect to persons with Limited English Proficiency (LEP). Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin by any entity receiving federal financial assistance.

To ensure compliance with the American with Disabilities Act (ADA) of 1990 which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, state and local government services public accommodations, transportation, and telecommunications.

III. GUIDELINES:

A. Materials that need to be reviewed include:

1. Press releases, any brochure, flyer, pamphlet, newsletter, booklet, book, report, manual, poster, invitation or similar publication
2. Website and web-based materials
3. Logos
4. Promotional plans and materials, including print and broadcast advertisements, "spots," and public service announcements (PSAs)
5. Scripts for audiovisual presentations for outside the department
6. Training manuals

B. Materials that do NOT need to be reviewed include:

1. Intra-agency and interagency communications, such as letters, memos, instructions, and correspondence.
2. State supplied brochures, posters, flyers, etc.
3. Brochures supplied by other professional agencies.
4. Materials printed from the internet or obtained from a reputable/ approved health source, such as **websites maintained by governmental entities, national coalitions, and educational institutions**:

C. General Review Process: The following multilevel process is expected to be utilized for all media created within the agency for dissemination outside the agency.

1. The creator is expected to thoroughly review the media product for technical and grammatical errors as well as factual accuracy.
2. Program supervisors are expected to ensure that all products/publications originating within their section of the agency are factual, accurate, and conform to agency and/or county policies.
3. Review of product by the Public Information Officer/Health Education Program Manager for overall style, readability correct usage, design, and compliance with Media Policy. Estimate approximately one week for review to be completed by the Public

Information Officer. For larger products/documents, a longer time period may be required.

4. Once reviewed, the Public Information Officer will contact the creator of the media product with any suggestions, modifications, and/or comments.

5. When final changes have been made by either the creator or Public Information Officer, the media product will be submitted to the Health Director for final approval.

6. Upon approval from the Health Director, the Public Information Officer will either release the media product to the appropriate media contact (see attached Media Contact List) or release the media product back to the creator for dissemination (whichever is applicable).

D. English-to-Spanish Media Translation Process: Materials that have been translated or need to be translated to Spanish or another language must also be reviewed by at least a qualified bilingual interpreter**/translator**.

1. Document translation is available within the agency.

2. Contact one of the bilingual interpreters for assistance in document translation.

   a. Time: Please respect the fact that agency bilingual interpreters also have other responsibilities.
   b. Unless the information is time sensitive, for example press release, important health/community notice, alert, etc., allow at least two weeks for the translation process. For larger products/documents, a longer period may be required.

3. While waiting on the translation process, the English version of the translation should also be submitted to the Public Information Officer for review. Estimate approximately one week for review to be completed by the Public Information Officer. For larger products/documents, a longer time period may be required.

4. Once translation is complete, the bilingual interpreter is expected to submit a written note, email with the translated document to the Public Information Officer verifying that the document has been appropriately translated by a qualified bilingual interpreter

5. Once the translated material(s) have been reviewed, the Public Information Officer will contact the creator of the media product with any suggestions, modifications, and/or comments.

6. When final changes have been made by either the creator or Public Information Officer, the media product will be submitted to the Health Director for final approval.

7. Upon approval from the Health Director, the Public Information Officer will either release the media product to the appropriate media contact (see attached Media Contact List) or release the media product back to the creator for dissemination (whichever is applicable).

E. English-to-Any Foreign Language (other than Spanish) Media Translation Process:

1. All media needing translation to a foreign language other than Spanish should be submitted to an Agency bilingual interpreter for possible outsourcing.

2. Follow the "General Review Process" previously mentioned in this policy once materials have been translated.

F. Required Elements on all Print Material:

1. Date:

   a. Developed
   b. Reviewed
   c. Revised

2. Agency and program logo(s)

3. Free Language Assistance Statement (in response to Title VI of the Civil Rights Act of 1964):

   This is a statement indicating that Limited English Proficient individuals will have access to FREE language assistance/ translation. This is required in "all outreach material that is routinely disseminated to the public" (CCPHD Title VI Language Access Plan) and required by federal policy.

G. Optional (Strongly Recommended) Elements on Print Material:

1. Non-discrimination statement(s):

   a. The Division of Public Health Services does not discriminate on the basis of race, color, national origin, creed sex, religion, age, or political affiliation.

Spanish: El Departamento de Salud Pública del Condado de Rockingham no discrimina basado en raza, color, origen nacional, sexo, religión, endad, incapacidad en el empleo o la provisión de servicios.

b. The Division of Public Health Services is an equal opportunity employer and provider.

Spanish: El Departamento de Salud Publica del Condado de Rockingham es proveedor y empleador que ofrece una oportunidad de igualdad para empleo.

c. Contact Information.

i. The name and title of the primary person for the public to contact for more information.
ii. Telephone Number
iii. Email Address
iv. Agency and/or program website address
- www.rockinghamcounty.dhhs.org

H. Annual Media Action Plan:

A media action plan will be developed annually by the Health Education Program Manager. The health topic(s) are tentative but provide a guide for the agency to follow as a means of disseminating health education media to the community.

I. Health Advisory Communications Plan:

1. In the Event of a Communicable Disease/Bioterrorism/Natural Disaster notify appropriate State Agency dependent upon event.

2. Establish a Health Advisory Communications Plan:

a. Identify all community partners to be notified. This may include:

i. pharmacists
i. veterinarians
ii. local hospitals
iii. infection control practitioners
iv. Rockingham County Schools Superintendent
v. County Officials
vi. Board of Health and Human Services
vii. Commissioners
viii. Emergency Services Director

ix. Rockingham County Manager
x. Mental Health Director
xi. American Red Cross
xii. Salvation Army
xiii. Medical Examiner

b. Identify all media outlets to contact such as local radio, tv, newspaper, and county website (see attached Media Contact List)

c. Information will be disseminated to the medical community and community at large as appropriate utilizing methods such as:

i. Health Alert Network (HAN) System
ii. E-mail
iii. Fax
iv. Mail

d. Develop the Communications Plan

i. Activate RCDPH Epi-Team
ii. Delegate internal responsibilities
iii. The Health Director and the Agency PIO (Health Education Program Manager) will develop press releases and news media advisories.

e. The Health Director will collaborate with the State NC DHHS Public Information Officer prior to developing news releases to correctly identify information to be disseminated.

f. The RCDHHS Media Policy will be followed for the development of Media Releases.

g. The following elements may be implemented into the news release but not limited to:

i. current information, facts, definitions, characteristics, etc. related to the event
ii. symptoms to be observed and reported
iii. identify who to report symptoms to
iv. recommendations for prevention and control measures to limit the exacerbation of the event

h. The following elements may be implemented with the health advisories to the medical community but not limited to:

i. Event fact sheet
ii. Information for clinicians
a) Clinical features

b) Rx and reporting
c) Recommendations for treatment

iii. Recommendations for reporting
iv. If state is performing testing instructions for obtaining specimens, handling, and specimen shipping
v. Recommendations for follow-up

i. For larger scale event of which the RCDHHS has exceeded its capacity to respond, the Public Information Officer and the Joint Information Center (JIC) in collaboration with the NC Public Information Officer will implement measures. The Rockingham County Emergency Operations Plan will be followed at this time (refer to Annex C).

Rev/di

MEDIA CONTACT LIST

TOPIC/TITLE: _____

DATE: _____

Media	Contact	Phone	Fax	Email	Prefer	Distributed/Deadline	Notes
Newspapers							
Reidsville Review PO Box 2157 Reidsville, NC 27323	**J. Dexter**	336-349-4331 Ext. 6139 (C) 965-9349	336-349-4320	news@reidsvillereview.com **jdexter@rockinghamnow.com**	Email Fax	Sunday, Tues-Fri/ At least one week (before 11am)	
The Eden Daily News PO Box 308 Eden, NC 27289	**J. Dexter**	336-349-4331 Ext. 6139 (C) 965-9349	336-349-4320	news@reidsvillereview.com **jdexter@rockinghamnow.com**	Email	Sunday, Tues-Fri/ At least one week	
The Madison Messenger PO Box 508 Madison, NC 27025	**J. Dexter**	336- 349-4331 Ext. 6139 (C) 965-9349	336-349-4320	news@reidsvillereview.com **jdexter@rockinghamnow.com**	Email	Wed, Fri/ 5pm on Mon & Wed	
News & Record (Eden Office) 203 East Harris Place Eden, NC 27288	Danielle.battaglia@news-record.com Carolyn Booth (Calendar Editor)	336-627-4881 x 116 336-627-4881 x110	336-623-2245 336-623-2245	***Danielle.battaglia@news-record.com** cbooth@news-record.com	Email	Daily/ Monday for the following Sunday (breaking news by 10pm) at least 2 weeks in advance before event	
Eden's Own…Journal 5197 Hwy 14 Eden, NC 27288	Lisa Doss **Elizabeth Doss**	336-627-9234	(336) 613-0325 (Cell) (336) 613-3025*	info@edensown.com ***lisag@edensown.com** ***elizabethdoss@edensown.com**	Email	1st of each month/ 21st-24th of each month	
Rockingham County Events and News Online	Roy Sawyer	336-398-6003	866- 736-9093 (Fax)	***roy@rceno.com** www.rceno.com		Daily	
Rockingham County Government	Mable S. Scott	336-342-8342		**mscott@co.rockingham.nc.us**	Call or email	Immediately	

Mike Moore PO Box 279 Madison, NC 27027	Mike Moore www.MikeMoore.Media	336-932-1881	336-548-4636	rockinghamcountync@gmail.com	Call or email		
1130 WCLW Gospel 116 S. Franklin St. Reidsville, NC 27320	Brenda Carter Director	(336) 634-1345					
TV Channels	**Contact**	**Phone**	**Fax**	**Email**	**Prefer**	**Deadline**	
WFMY Channel 2 PO Box TV2 Greensboro, NC 27420	Assignment Desk Community Calendar Devetta Blount WFMY News 2 Executive Producer Of News Assignments 336-379-9316	336-379-9369 336-379-5704	336-230-0971 336- 273-9433	assignmentdesk@wfmy.com dpickett@wfymgannett.com **news@wfmy.com** **dblount@wfmy.com**	Call or email email	4 weeks before event	
WGHP Fox 8 HP-8 High Point, NC 27261	News Dept. ~ **Lesa Layno or David**	336-275-1850	336- 841-5169	**news@wghp.com**		4 weeks before event	
WXII Channel 12 PO Box 11847 Winston-Salem, NC 27116	News Desk **Obin Johnson**	336-721-9944	336 721-0856	Newstips@wxii12.com **cojohnson@hearst.com**	Call or email	4 weeks before event	
Channel 14 5921 W. Friendly Ave. Suite A Greensboro, NC 27410	**Ria Matthews** **Derrick Helenbrand**		336 856-9497	**media@news14.com** ria.matthews@news14.com			
Star News~Channel 5 Reidsville, NC 115 Gilmer St. Reidsville, NC 27320	Bobby Martin **Matt Smith** Mark Childress (News Anchor) **Debbie Moore** News Anchor/Reporter	**336-349-5594** Out-of-town # 261-266-4986 342-2668 (O) 344-1180 (C) 336-344-5539	336-342-2733	**starnewscorp@yahoo.com** mark.childrey@outlook.com news@wgsr47.com wgsrtv@gmail.com			

Department of Health and Human Services- Communication Office	Valerie Procopio			Valerie.procopio@dhhs.nc.gov			

Note: If more than one contact source is given, use contact information with asterisk as initial source(s) Please provide any updates or changes to Katrina for revision. Revised 12/3/19 (KRW)

Rockingham County Department of Health and Human Services
Division of Public Health Services
Media Contact Checklist

Request Date: _____

Reporter: _____ Deadline: _____

Station/Publication: _____ Phone: _____

RCDHHS Spokesperson: _____ Phone: _____

NOTE: Remember to incorporate public health concept and/or Division of Public Health Services into message. Suggest visuals, sounds, photo opportunities.

☐ **INFORMATION REQUEST**:

Topic of Request: _____

Comments:

☐ **INTERVIEW**:

Three Main Points:

1. _____
   _____
2. _____
   _____
3. _____
   _____

Media Bite (1-2 sentences that sum up your main points):

Anticipated Questions:

1.

2.

3.

For Health Education Use Only:
Media Coverage Documentation

Print: Date:_____ Section:_____ Page number:_____ Column Inches:_____ Reach:_____
TV: Date:_____ Time(s):_____ Reach:_____
Radio: Date:_____ Time(s):_____ Reach:_____

/krw

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PUBLIC ACCESS TO DATA

DATE DEVELOPED: 11/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/24

I. POLICY:

The citizens of Rockingham County should have access to all public health department data and local health status information, with the exception of information that can not be released due to confidentiality purposes and the Health Insurance Portability and Accountability Act (HIPAA).

II. PURPOSE:

To provide a mechanism by which the public can access available data and local health status information that is maintained in agency data systems.

To provide a mechanism to guide responses to requests for information from the general public, media, and elected officials.

III. GUIDELINES:

All public requests for information should be directed to the Agency's Public Information officer (PIO). The PIO will then, with the approval of the Health Director, provide the requested information/data as long as the information and/or data being requested is not legally protected information preventing public disclosure. All data made assessable to the public will be in compliance with HIPAA regulations in order to maintain confidentiality.

The agency website can also be utilized by the public to obtain health related information and data. The agency's website will be maintained and updated on a regular basis by the PIO. Specific data that can be found on the website are the Rockingham County Community Health Assessment, the Rockingham County State-of-the-County Health Report, etc. The Agency website can be accessed at: www.rockinghamcounty.dhhs.org.

The Health Education Section of the agency will maintain a Partnership mailing list who will receive health related data and information on an ongoing basis.

The agency PIO maintains a collection of all Press Releases submitted to media which can be accessed by the public upon request.

Media Requests for Information: All requests from Media should be channeled to the agency PIO who will work with the agency administrative staff to obtain the necessary public information to meet the request.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PURLIC HEALTH SERVICES

Health Education Section
Health Education Program Manager Orientation Checklist

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A. Division of Public Health Services 1. Mission, vision, goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B. Review of Policies: 1. Agency Safety a. Fire prevention and plan b. Smoke sensors c. Fire Extinguishers d. Exit signs e. Security f. Tornado Plan g. Emergency Preparedness • Health Education Program Manager Disaster Training • Health Education Program manager Disaster Assistance • Emergency Shelters and Team Assigned		
2. Personal Safety a. Agency Worksite b. Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for • Infection Control		

3. Infection control a. Personal Hygiene b. Aseptic Technique c. Communicable disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and handling supplies g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB skin Test • Hepatitis B or Waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management • Vaccine transporting, handling and storage k. Identifying, handling, and disposing of hazardous materials l. Safety Data sheets m. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable gown • Vent mask • Antibacterial hand wash • Spill kit • N-95-Respirator Mask • Goggles/Face Shield		
4. Screening and reporting for child and adult abuse and neglect		
5. Community Resources and Collaboration		
6. Continuing Education requirements		
7. Employee Performance Evaluation		
C. Quality Improvement 1. Quality Improvement Council Committee and purpose 2. Call supervisor by 7:00am if not reporting to work 3. Job Description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Quarterly Audits if applicable c. Incident Reports		

d. Blood borne Pathogen exposure e. Client complaints		
D. Preceptor Assigned		
E. Orientation Period		
F. Program Area 1. Introduction to worksite and Agency staff 2. Introduction to Health Education Section a. Provides supervision to Health Education Section • Public Health Education Specialists • **Programs for Aging Populations** i. A Matter of Balance ii. Chronic Condition Management • **Student Health Centers** • **Physical Activity & Nutrition** **i. Body Treats** **ii. Eat Fresh Initiative** **iii. Diabetes Prevention** • **Maternal & Child Health** **i. Safe Sleep/Crib for Kids** **ii. Child Passenger Safety** • **Healthy Communities** • **Summer Camp Presentations** • **Tobacco Cessation** • **Health Equity** • **Community Presentations** 3. **Introduction to Community Health Assessment Process and State of the County Health Process** 4. **Introduction to Accreditation Process** 5. Schedule a. Monday-Friday, 8:00am-5:00pm b. Some nights and weekends as needed c. **Flex** time 6. Introduction to Rockingham County a. Map overview b. County Resources c. Tour of County 7. Client Satisfactions a. **Public Health Education Specialists** b. **Family Planning Clients** 8. Public Information Officer (PIO) a. Health Education Program Manager		

also serves as Agency PIO b. All media request are channeled to PIO c. PIO adheres to Annual Media Action plan d. Review media policy e. Attend PIO Training f. Contact county PIO g. Maintain Agency website 9. Funding a. Search for funding options on an ongoing basis b. Responsible for grant writing as appropriate c. Responsible for reviewing 10. Administrative Team a. Serve on Administrative Team b. Bi-weekly meetings, Tuesdays at 9 am, Large Conference Room 11. Communities/Boards/Meetings a. School Health Advisory Council (SHAC) b. Student Health Center Advisory Board c. **Quality Improvement** d. **Rockingham County Partnership for Children: Kids Ready** e. **Rockingham County Partnership for Children: Family Advisory Board** f. **Rockingham County Health Collaborative** 12. AV Equipment Closet a. Responsible for all equipment in closet b. **Responsible for loaning/collecting borrowed items**		

Date Developed: 10/10/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/24

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

* When completed submit to the Health Education program manager for filing.

* The Orientation Checklist should be completed at the end of the employee's probationary status.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Health Education Section
Health Education Specialist Orientation Checklist

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
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2. Personal Safety a. Agency Worksite b. Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for • Infection Control		

3. Infection Control a. Personal Hygiene b. Aseptic Technique c. Communicable disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and handling supplies g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB skin Test • Hepatitis B or Waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment management • Vaccine transporting, handling & storage k. Identifying, handling, and disposing of hazardous materials l. Safety Data sheets m. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable gown • Vent mask • Antibacterial hand wash • Spill kit • N-95-Respirator Mask • Goggles/Face Shield		
4. Screening and reporting for child and adult abuse and neglect		
5. Community Resources and Collaboration		
6. Continuing Education requirements		
7. Employee Performance Evaluation		
C. Professional Expectations 1. Call supervisor by 7:00am if not reporting to work 2. Job Description 3. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Quarterly Audits if applicable c. Incident Reports d. Blood borne Pathogen exposure		

e. Client complaints		
D. Orientation Period		
E. The Public Health Education Specialist will be oriented to: 1. Accreditation Overview 2. **Community Health Assessment and State of the County Health Overview** 3. Program Areas a. Introduction to worksite and Agency staff b. Introduction to Health Education Section **& Programs** i. **Programs for Aging Populations** ii. **Student Health Centers** iii. **Physical Activity & Nutrition** **iv. Maternal & Child Health** **v. Healthy Communities** **vi. Health Equity** **vii. Tobacco Cessation** **viii. Community Presentations** c. Schedule • Monday-Friday, 8:00am-5:00pm Some nights and weekends as needed • Flex time • Comp time d. Schedule training workshops as needed for current programs e. Review current budget expenditures and future budgeting plans		

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

* When completed submit to the Health Education Program Manager for filing.

* The Orientation Checklist should be completed at the end of the employee's probationary status.

Date developed: 12/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised 6/24

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Health Education Section
Health Education Program Manager
Competency Skills Checklist

		SUBJECT	DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Health Education Program Manager applies theoretical concepts in practice.						
	B.	The Health Education Program Manager systematically collects data that is comprehensive and accurate.						
	C.	The Health Education Program Manager intervenes to promote, maintain or restore health, to prevent illness, to minimize complications and effect rehabilitation.						
	D.	The Health Education Program Manager evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	E.	The Health Education Program Manager may participate in peer review and program audits to assure quality of services.						
	F.	The Health Education Program Manager collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	G.	The Health Education Program Manager reports to work area as assigned in a timely manner.						
	H.	The Health Education Program Manager introduces self to client.						
	I.	The Health Education Program Manager uses appropriate communication techniques to make community comfortable, addresses their concerns and telephone calls with dignity and respect.						
	J.	The Health Education Program Manager effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	K.	The Health Education Program Manager demonstrates support of agency by involvement in community activities.						
	L.	The Health Education Program Manager uses chain of command for problem resolution.						
	M.	The Health Education Program Manager adheres to appropriate dress and grooming.						
	N.	The Health Education Program Manager maintains a reliable attendance record.						
	O.	The Health Education Program Manager safely and accurately assists other staff during projects and activities as it pertains to work assignment.						
	P.	Knowledgeable and maintains client rights and confidentiality.						
	Q.	Implements measures to maintain client confidentiality.						

	R.	Demonstrates understanding and implementation of HIPAA compliance.						
	S.	COMMUNICATION:						
	T.	1. Listens to others						
		2. Speaks clear and effectively to individuals						
		3. Collaborates and works well with other health care providers, professionals, and community representatives displaying courtesy, tact and patience.						
		4. Appropriately introduces self to client in a friendly/professional manner.						
		5. Uses appropriate communication techniques to make the client comfortable.						
		6. Addresses client concerns and telephone calls with dignity and respect.						
		7. Answers telephone in a professional manner – (Health Education, this is _____ speaking. How may I help you?)						
		8. Communicates effectively in writing.						
		9. Reviews and critiques others' writing.						
	U.	PROBLEM SOLVING:						
		1. Recognizes and defines problems.						
		2. Analyzes relevant information.						
		3. Encourages alternative solutions and plans to solve problems.						
	V.	INTERPERSONAL SKILLS:						
		1. Considers and responds appropriately to the needs, feelings, capabilities and interests of others.						
		2. Provides feedback.						
		3. Treats others equitably.						
	W.	SELF-DIRECTION:						
		1. Realistically assesses own strengths, weaknesses, and impact on others.						
		2. Seeks feedback from others.						
		3. Works persistently towards a goal.						
		4. Demonstrates self-confidence.						
		5. Invests in self-development.						
		6. Manages own time efficiently.						
	X.	FLEXIBILITY:						
		1. Adapts to change in the work environment.						
		2. Effectively copes with stress.						
	Y.	DECISIVENESS:						
		1. Takes action and risk when needed.						
		2. Makes difficult decisions when necessary.						
	Z.	TECHNICAL COMPETENCE:						
		1. Demonstrates technical proficiency and an understanding of its impact in areas of responsibility.						
	AA.	LEADERSHIP:						
		1. Demonstrates and encourages high standards of behavior.						
		2. Adapts leadership style to situations and people.						
		3. Empowers, motivates, and guides others.						
	BB.	MANAGING DIVERSITY:						

		1. Recognizes the value of cultural, ethnic, gender and other individual differences.						
		2. Provides employment and development opportunities for a diverse workforce.						
	CC.	CONFLICT MANAGEMENT:						
		Participates/seeks to resolve confrontations, disagreements, and complaints in a constructive manner.						
	DD.	TEAM BUILDING:						
		Fosters cooperation, communication, and consensus among groups.						
	EE.	INFLUENCEING/NEGOTIATING:						
		1. Networks with and provides information to key groups and individuals.						
		2. Appropriately uses negotiation, persuasion, and authority in dealing with others to achieve goals.						
	FF.	HUMAN RESOURCE MANAGEMENT:						
		1. Ensures effective recruitment, selection, training, performance, appraisal, recognition, and corrective/disciplinary action.						
		2. Promotes affirmative employment, good labor relations, and employee wellbeing.						
	GG.	CREATIVE THINKING:						
		1. Develops insights and solutions.						
		2. Fosters innovation among others.						
	HH.	PLANNING/EVALUATING:						
		1. Establishes policies, guidelines, plans, and priorities.						
		2. Identifies required resources.						
		3. Plans and coordinates with others.						
		4. Monitors progress and evaluates outcomes.						
		5. Improves organizational efficiency and effectiveness.						
	II.	COMMUNITY/CLIENT ORIENTATION:						
		1. Actively seeks community/client input.						
		2. Ensures community/client needs are met.						
		3. Continuously seeks to improve the quality of service, products, and processes.						
	JJ.	CONTROLS/INTEGRITY:						
		1. Ensures the integrity of the organization's processes.						
		2. Promotes ethical and effective practices.						
	KK.	FINANCIAL MANAGEMENT:						
		1. Prepares and justifies program budget(s).						
		2. Monitors expense.						
	LL.	TECHNOLOGY MANAGEMENT:						
		1. Encourages staff to stay informed about new technology.						
		2. Applies new technology to organizational needs.						
		3. Ensures staff members are trained and capable.						
	MM.	VISION:						
		1. Creates a shared vision of the organization.						
		2. Promotes wide ownership.						
		3. Champions organizational change.						
	NN.	EXTERNAL AWARENESS:						
		1. Stays informed on laws, policies, administration priorities, trends, special interests, and others.						

		2. Considers external impact of statements/actions.							
		3. Uses information in decision-making.							
II.	**Competencies As A Health Educator Assessing Individual and Community Needs:**								
	A.	Obtain health-related data about social and cultural environments, growth and development factors, needs and interests.							
		1. Select valid sources of information about health needs and interests.							
		2. Utilize computerized sources of health-related information.							
		3.							
		4. Employ or develop appropriate data-gathering instruments. Apply survey techniques to acquire health data.							
	B.	Distinguish between behaviors that foster and those that hinder well-being.							
		1. Investigate physical, social, emotional and intellectual factors.							
		2. Identify behaviors that tend to promote or compromise health.							
		3. Recognize the role of learning and affective experience in shaping patterns of health behavior.							
	C.	Infer needs for health education on the basis of obtained data.							
		1. Analyze needs assessment data.							
		2. Determine priority areas of need for health education.							
III.	**Planning Effective Health Education/Promotion Programs:**								
	A.	Recruit community organizations, resource people and potential participants for support and assistance in program planning.							
		1. Communicate need for the program to those who will be involved.							
		2. Obtain commitments from personnel and decision makers who will be involved in the program.							
		3. Seek ideas and opinions of those who will affect or be affected by the program.							
		4. Incorporate feasible ideas and recommendations into the planning process.							
	B.	Develop a logical scope and sequence plan for a health education program.							
		1. Determine the range of health information requisite to a given program of instruction.							
		2. Organize the subject areas comprising the scope of a program in logical sequence.							
	C.	Formulate appropriate and measurable program objectives.							
		1. Infer educational objectives that facilitate achievement of							
		2. specified competencies.							
		3. Develop a framework of broadly stated, operational							
		4. objectives relevant to proposed health education program.							
	D.	Design educational programs consistent with specified program objectives.							
		1. Match proposed learning activities with those implicit in the stated objectives.							
		2. Formulate a wide variety of the alternative educational methods.							
		3. Select strategies best suited to implementation of educational objectives in a given setting.							
		4. Plan a sequence of learning opportunities building upon, and reinforcing mastery of preceding objectives.							
IV.	**Implementing Health Education/Promotion Programs:**								
	A.	Exhibit competence in carrying out planned educational programs.							

		1. Employ a wide range of educational methods and techniques.						
		2. Apply individual or group process methods as appropriate to given learning situations.						
		3. Utilize instructional equipment and other instructional media.						
		4. Select methods that best facilitate the practice of program objectives.						
	B.	Infer enabling objectives as needed to implement instructional programs in specified settings.						
		1. Pretest learners to ascertain present abilities and knowledge relative to proposed program objectives.						
		2. Develop subordinate measurable objectives as needed for instruction.						
	C.	Select methods and media best suited to implement program plans for specific learners.						
		1. Analyze learner characteristics, legal aspects, feasibility and other considerations influencing choices among methods.						
		2. Evaluate the efficacy of alternative methods and techniques capable of facilitating program objectives.						
		3. Determine the availability of information, personnel, time and other resources available to implement the program for a given audience.						
	D.	Monitor educational programs, adjusting objectives and activities as necessary.						
		1. Compare actual program activities with the stated objectives.						
		2. Assess the relevance of existing program objectives to current needs.						
		3. Revise program activities and objectives as necessitated for participant success.						
		4. Appraise applicability of resources and materials relative to given educational objectives						
V.	**Evaluating Effectiveness of Health Education/Promotion Programs:**							
	A.	Develop plans to assess achievement of programs objectives.						
		1. Determine standards of performance to be applied as criteria of effectiveness.						
		2. Establish a realistic scope of evaluation efforts.						
		3. Develop an inventory of existing reputable and reliable tests and instruments.						
		4. Select appropriate methods for evaluating program effectiveness.						
	B.	Carry out evaluation plans.						
		1. Facilitate administration of the tests and activities specified in the plan.						
		2. Utilize data-collecting methods appropriate to the objectives.						
		3. Analyze resulting evaluation data.						
	C.	Interpret results of program evaluation.						
		1. Apply criteria of effectiveness to obtained results of a program.						
		2. Translate evaluation results into terms easily understood by others.						
		3. Report effectiveness of educational programs in achieving proposed objectives.						

	D.	Infer implication from findings for future program planning.						
		1. Explore possible explanations for important evaluation findings.						
		2. Recommend strategies for implementing results of evaluation.						
VI. Coordinating Provision of Health Education/Promotion Services:								
	A.	Develop a plan for coordinating health education services.						
		1. Determine the extent of available health education services.						
		2. Match health education services to proposed program activities.						
		3. Identify gaps and overlaps in the provision of collaborative health services.						
	B.	Facilitate cooperation between and among levels of program personnel.						
		1. Promote collaboration and feedback among personnel related to the program.						
		2. Apply various methods of conflict reduction as needed.						
		3. Analyze the role of health educator as liaison between program staff and partnering organizations.						
	C.	Formulate practical modes of collaboration among health agencies and organizations.						
		1. Stimulate development of cooperation among personnel responsible for community health education programs.						
		2. Suggest approaches for integrating health education within existing health program.						
		3. Develop plans for promoting collaborative efforts among health agencies and organizations with mutual interests.						
	D.	Organize in-service training programs for teachers, volunteers, and other interested personnel.						
		1. Plan an operational, competency-oriented training program.						
		2. Utilize instructional resources that meet a variety of in-service training needs.						
		3. Demonstrate a wide range of strategies for conducting in-service training program.						
VII.	**Acting As A Resource Person In Health Education/Promotion:**							
	A.	Utilize computerized health information retrieval system effectively.						
		1. Match an information need with the appropriate retrieval system.						
		2. Access principal online and other database health information resources.						
	B.	Establish effective consultative relationships with those requesting assistance in solving health-related problems.						
		1. Analyze parameters of effective consultative relationships.						
		2. Describe special skills and abilities needed by health educators for consultation activities.						
		3. Formulate a plan for providing consultation to other health professionals.						
		4. Explain the process of marketing health education consultative services.						
	C.	Interpret and respond to requests for health information.						

		1. Analyze general processes for identifying the information needed to satisfy a request. 2. Employ a variety of approaches in referring requests to valid sources of health information.						
	D.	Select effective educational resource materials for dissemination.						
		1. Assemble educational material of value to the health of individuals and community groups. 2. Evaluate the worth and applicability of resource materials for given audiences. 3. Apply various processes in the acquisition of resources materials. 4. Compare different methods for distributing educational materials.						
VIII.	**Communicating Health And Health Education/Promotion Needs, Concerns and Resources:**							
	A.	Interpret concepts, purposes and theories of education.						
		1. Evaluate the state-of-the-art of health education. 2. Analyze the foundations of the discipline of health education. 3. Describe major responsibilities of the health educator in the practice of health education.						
	B.	Predict the impact of societal value systems on health education programs.						
		1. Investigate social forces causing opposing viewpoints regarding health education needs and concerns. 2. Employ a variety of strategies for dealing with controversial health issues.						
	C.	Select a variety of communication methods and techniques in providing health information.						
		1. Utilize a wide range of techniques for communicating health and health education information. 2. Demonstrate proficiency in communicating health information and health education needs.						
	D.	Foster communication between health care providers and consumers.						
		1. Interpret the significance and implications of health care providers' messages to consumers. 2. Act as liaison between consumer groups and individuals and health care provider organizations.						
IX.	**General Competencies:**							
	A.	Reports to workstation as assigned in a timely manner.						
	B.	Effectively works as a team player with flexibility in work.						
	C.	Demonstrates support of agency by involvement in community activities.						
	D.	Uses Chain of command for problem resolution.						
	E.	Adheres to appropriate dress/grooming code.						
	F.	Maintains a reliable attendance record.						
	G.	Demonstrates knowledge of computer system.						
	H.	Demonstrates thorough knowledge of typing skills, proficiency and speed.						
	I.	Demonstrates proficiency in general office procedures.						
	J.	Demonstrates ability to retrieve statistical information as needed.						
	K.	Adheres to agency policies and procedures.						
		- Reviews annually.						
	L.	Adheres to Health Education Section Policies and Procedures						
		- Reviews annually.						

	M.	Demonstrates understanding and implementation of HIPAA compliance.							
X.	**Infection Control Measures:**								
	A.	HANDWASHING:							
		1.	Washes hands at least 30 seconds under running water.						
		2.	Uses a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.						
		3.	Keep fingers pointed down, lower than wrists to prevent contamination of the arms.						
		4.	Rinse hands under running water allowing water to flow from the upper arm down over the hands.						
		5.	Dry hands thoroughly with a dry paper towel.						
		6.	Use a separate paper towel to turn off the faucet.						
		7.	Use lotion to prevent drying of the skin.						
		8.	Use gel or foam cleanser to wash hands only until you can use running water.						
	B.	Disposal Of Soiled Materials							
	C.	Disposal Of Excretions							
	D.	Universal Precautions							
	E.	Has attended initial orientation for OSHA Standards 29 CFR 1910.1030 and annually thereafter.							
	F.	Demonstrates an understanding of modes of transmission of blood borne diseases.							
	G.	Demonstrates knowledge and selection of personal protective equipment.							
	H.	Practices hand washing to prevent spread of disease.							
	I.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.							
XI.	**Skills Performance – Body Mechanics:**								
	A.	Sitting:							
		1.	Positions buttocks against the back of chair.						
		2.	Places feet flat on floor at 90-degree angle to lower legs.						
		3.	Flexes hip slightly so knees are higher than ischial tuberosities.						
		4.	Flexes lumbar spine slightly.						
		5.	Flexes elbows and places forearms on armrest, if applicable.						
	B.	Standing:							
		1.	Keeps feet parallel 6 inches to 8 inches apart.						
		2.	Places equal weight on both legs.						
		3.	Flexes knees slightly.						
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.						
	C.	Walking:							
		1.	Assumes the correct standing position.						
		2.	Steps forward a comfortable distance with one leg.						
		3.	Tilts the pelvis slightly forward and downward.						
		4.	Touches floor first with heel then ball of foot to toes.						

	D.	Pulling:							
		1.	Stands close to the object.						
		2.	Places on foot slightly ahead of the other.						
		3.	Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscles.						
	E.	Pushing:							
		1.	Places hands on object and flexes the elbows.						
		2.	Leans into the object by shifting weight from back leg to front leg.						
		3.	Applies smooth continuous pressure.						
	F.	Stooping:							
		1.	Stands with feet 10-13 inches apart.						
		2.	Places one foot slightly ahead of the other.						
		3.	Lowers self by flexing the knees.						
		4.	Places more weight on front foot than back.						
		5.	Keeps upper body straight (does not bend at the waist).						
		6.	Straightens knees keeping the back straight.						
	G.	Lifting and Carrying:							
		1.	Assumes stooping position directly in front of the object.						
		2.	Grasps object and tightens abdominal muscles.						
		3.	Stands up straight by straightening the knees.						
		4.	Carries the object close to the body waist high.						

_____ successfully demonstrates the above criteria in the clinical setting.

_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date

Rev/di

Developed: 10/27/05
Reviewed: 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/14

The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

References:

CalGuard (2005). Skills and Competencies of a Supervisor. Retrieved 27 October 2005 from www.calguard.ca.gov/cahr/pubs/supervisors'%20course/3%20Skills%20&%20Competencies%20of%20a%20Supv.ppt.

National Commission for Health Education Credentialing, Inc. (NCHEC), Society for Public Health Education (SOPHE), American Association for Health Education (AAHE). (2010a).

A competency-based framework for health education specialists - 2010. Whitehall, PA: Author.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Health Education Specialist
Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Health Education Specialist applies theoretical concepts in practice						
	B.	The Health Education Specialist systematically collects data that is comprehensive and accurate						
	C.	The Health Education Specialist provides health education that will restore health, to prevent illness, to minimize complications and effect rehabilitation						
	D.	The Health Education Specialist evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement						
	E.	The Health Education Specialist may participate in peer review and program audits to assure quality of services						
	F.	The Health Education Specialist collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience						
	G.	The Health Education Specialist reports to work area as assigned in a timely manner						
	H.	The Health Education Specialist introduces self to community						
	I.	The Health Education Specialist uses appropriate communication techniques to make community comfortable, addresses their concerns and telephone calls with dignity and respect						
	J.	The Health Education Specialist effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude						
	K.	The Health Education Specialist demonstrates support of agency by involvement in community activities						
	L.	The Health Education Specialist uses chain of command for problem resolution						
	M.	The Health Education Specialist adheres to appropriate dress and grooming						
	N.	The Health Education Specialist maintains a reliable attendance record						
	O.	The Health Education Specialist safely and accurately assists other staff during projects and activities as it pertains to work assignment						

	P.	The Health Education Specialist is knowledgeable and maintains client rights and confidentiality						
	Q.	The Health Education Specialist implements measures to maintain client confidentiality						
	R.	The Health Education Specialist demonstrates understanding and implementation of HIPAA compliance						
	S.	Social Learning Theory 1. Aims to change behavior in participants a. Personal Knowledge b. Skills c. Attitudes d. Interpersonal Relationships e. Environmental Influences						
	T.	Service learning 1. Community 2. Youth Development 3. APPC						
	U.	Health Belief Model 1. Motivation 2. Positive health actions 3. Avoid negative health consequences as prime motivation						
	V.	Objective 1. Accurately defines objectives 2. Writes measurable objectives						
II.	**Communication:**							
	A.	Collaborates and works well with other agencies, professionals, health care providers, and community representatives displaying courtesy, tact and patience						
	B.	Appropriately introduces self to clients in a friendly/professional manner						
	C.	Use appropriate communication techniques to make the client comfortable						
	D.	Addresses client concerns and telephone calls with dignity and respect						
	E.	Answers telephone in a professional manner. -Health Education, this is_____ speaking. How may I help you?						
III.	**Assessing Individual and Community Needs:**							
	A.	Obtain health-related data about social and cultural norms, growth and development factors, needs and interests 1. Select valid sources of information about health needs interests. 2. Utilize computerized sources of health-related information. 3. Develop appropriate data-gathering instruments 4. Apply survey techniques to acquire health data						

	B.	Distinguish between behaviors that foster and those that hinder well-being 1. Investigate physical, social, emotional and intellectual factors influencing health behaviors 2. Identify behaviors that tend to promote or compromise health 3. Recognize the role of learning and affective experience in shaping patterns of health behavior						
	C.	Infer needs for pregnancy prevention on the basis of obtained data 1. Analyze needs assessment data 2. Determine priority areas of need for pregnancy prevention						
IV.	**Planning Effective Health Education/Pregnancy Prevention Programs:**							
	A.	Recruit members of Coalition, resource people and potential participants for support and assistance in program planning 1. Communicate what the program is and why it is needed 2. Obtain commitments from program participants 3. Incorporate feasible ideas and recommendations into the planning process						
	B.	Develop a schedules plan for prevention program 1. How many session to be presented and where 2. Organize subject areas in sequence						
	C.	Formulate appropriate and measurable program objectives 1. Each session of curriculum has the objectives for the session 2. Develop objectives for Coalition based on what you wish to accomplish						
	D.	Design educational programs consistent with specified program objectives 1. Match proposed learning activities with those implicit in the stated objectives 2. Formulate a wide variety of the alternative educational methods 3. Select strategies best suited to implementation of educational objectives in a School setting. 4. Plan other learning opportunities that will reinforce your objectives						
V.	**Implementing Health Education/Pregnancy Prevention Programs:**							
	A.	Exhibit competence in facilitating planned educational programs 1. Apply individual or group process methods based on age appropriateness 2. Utilize instructional equipment and media. 3. Employ a wide range of educational methods and techniques 4. Select programs that have been chosen as Best Practices						

	B.	Prior to program implementation, ascertain information needed to relay 1. Retest learners for knowledge and skills 2. Posttest learners for knowledge and skills gained after instruction						
	C.	Select methods and strategies best suited to implement program plans for specific learners 1. Analyze learner characteristics, legal aspects, feasibility and other considerations influencing choices among methods 2. Determine the availability of information, time and equipment needed to implement the program for a given audience 3. Evaluate the efficacy of alternative methods and techniques						
	D.	Monitor educational programs, adjusting objectives and activities as necessary 1. Compare session's program activity with objectives 2. Assess the relevance of existing program objectives to current needs 3. Revise program activities and objectives as necessitated by changes in learner's needs 4. Appraise applicability of resources and materials relative to given educational objectives						
VI.	**Evaluating Effectiveness of Health Education/Pregnancy Prevention Programs:**							
	A.	Program should have focused behavioral objectives 1. Delay of onset for sexual behavior 2. Clear and concise messages about sexual activity and/or contraceptive use 3. Provide information about the risks associated with teen sexual activity and methods to prevent pregnancy and STD's 4. Incorporate multiple teaching methods and personalize information to individual's needs 5. Tailored to participant's age level, culture, and level of sexual experience 6. Provide appropriate training for facilitators						
	B.	Develop Plans to assess achievement of program objectives 1. Determine standards of performance to be applied as criteria of effectiveness 2. Use a quasi-experimental evaluation approach. 3. Test participants vs. control group on knowledge and skills 4. Develop an inventory of existing valid and reliable tests and instruments						
	C.	Carry out evaluation plans 1. Facilitate administration of the tests and activities specified in the plan						

		2. Utilize data-collecting methods appropriate to the objectives 3. Analyze resulting evaluation data						
	D.	Interpret results of program evaluation 1. Apply criteria of effectiveness to obtained result of a program 2. Translate evaluation results into terms easily understood by others 3. Report effectiveness of educational programs in achieving proposed objectives						
	E.	Infer implication for findings for future program planning 1. Explore possible explanations for important evaluation findings 2. Recommend strategies for implementing results of evaluation						
VII.	**Coordinating Provision of Health Education/Pregnancy Prevention Services:**							
	A.	Develop a plan for coordinating health education services 1. Determine the extent of available health education services 2. Match health education services to proposed program activities 3. Identify the gaps and overlaps in the provision of collaborative health services						
	B.	Facilitate cooperation between and among levels of program personnel 1. Promote cooperation and feedback among Student Health Center/School personnel related to the program. 2. Apply various methods of conflict resolution as needed 3. Act as a liaison between program participants, outside groups, and organizations						
	C.	Formulate practical modes of collaboration among health agencies and organizations 1. Stimulate development of cooperation among Youth Services/SOS, Student Health Center, and Schools 2. Suggest approaches for integrating health education within existing program (ex. above programs)						
	D.	Organize in-service training programs for colleagues, volunteers, and other interested personnel 1. Demonstrate a wide range of strategies for conducting in-service training programs 2. Utilize instructional resources that meet a variety of in-service training needs 3. Plan an operational, competency-oriented training program						

VIII.	**Acting as a Resource Person in Health Education/Pregnancy Prevention:**							
	A.	Utilize computerized health information retrieval system effectively 1. Match an information need with the appropriate retrieval system 2. Access principal online and other database health information resources						
	B.	Establish effective consultative relationships with those requesting assistance in solving health-related problems 1. Analyze parameters of effective consultative relationships 2. Describe special skills and abilities needed by health educators for consultative activities 3. Formulate a plan for providing consultation to other health professionals 4. Explain the process of marketing health education consultative services						
	C.	Interpret and respond to requests for health information 1. Analyze general processes for identifying the information needed to satisfy a request 2. Employ a wide range of approaches in referring requests to valid sources of health information						
	D.	Select effective educational resource materials for dissemination 1. Assemble educational material of value to the health of individuals and community groups 2. Evaluate the worth and applicability of resource materials for given audiences 3. Apply various processes in the acquisition of resource materials 4. Compare different methods for distributing educational materials						
IX.	**Communicating Health and Health Education/Promotion Needs, Concerns, and Resources:**							
	A.	Interpret concepts, purposes and theories of health education programs 1. Evaluate the state-of-the-art of health education 2. Analyze the foundations of the discipline of health educator in the practice of health education 3. Describe major responsibilities of the health educator in the practice of health education						
	B.	Predict the impact of societal value systems on health education programs 1. Investigate social forces causing opposing viewpoints regarding health education needs and concerns 2. Employ a wide range of strategies for dealing with controversial health issues						

	C.	Select a variety of communication methods and techniques in providing health information 1. Utilize a wide range of techniques for communicating health and health education information 2. Demonstrate proficiency in communicating health information and health education needs						
	D.	Foster communication between health care providers and consumers 1. Interpret the significance and implications of health care providers' messages to consumer 2. Act as a liaison between consumer groups and individuals and health care provider organizations						
X.	**General Competencies:**							
	A.	Demonstrates support of agency by involvement in community activities						
	B.	Demonstrates knowledge of computer system.						
	C.	Demonstrates thorough knowledge of typing skills, proficiency and speed						
	D.	Demonstrates proficiency in general office procedures						
	E.	Demonstrates ability to retrieve statistical information as needed						
	F.	Adheres to agency policies and procedures - Reviews annually						
	G.	Demonstrates understanding and implementation of HIPAA compliance						
XI.	**Infection Control Measures:**							
	A.	Hand washing 1. Washes hands at least 30 seconds under running water 2. Use a firm circular motion to provide friction to the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer no tot use bar soap 3. Keep fingers pointed down, lower than wrists to prevent contamination of the arms 4. Rinse hands under running water-allowing water to flow from the upper arm down over the hands 5. Dry hands thoroughly with a dry paper towel. 6. Use a separate paper towel to turn off the faucet 7. Use lotion to prevent drying of the skin. 8. Use gel or foam cleanser to wash hands only until you can running water 9. Disposal of soiled materials 10. Disposal of excretions 11. Universal Precautions 12. Has attended annual initial training for OSHA Standards 29 CFR 1910.1030 and annually							

		thereafter 13. Demonstrates an understanding of and practices universal precautions 14. Demonstrates an understanding of modes of transmission of blood borne diseases 15. Demonstrates knowledge and selection of personal protective equipment 16. Practices hand washing to prevent spread of disease 17. Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies						
XII.	**Skills Performance – Body Mechanics:**							
	A.	Sitting: 1. Position buttocks against the back of the chair 2. Place feet flat on floor at 90-degree angle to lower legs 3. Flexes hip slightly s knees are higher than ischial tuberosities 4. Flexes lumbar spine slightly 5. flexes elbows and places forearms on armrest, if applicable						
	B.	Standing: 1. Keeps feet parallel 6 inches to 8 inches apart 2. Places equal weight on both legs 3. Flexes knees slightly 4. Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back						
	C.	Walking: 1. Assumes the correct standing position 2. Steps forward a comfortable distance with one leg 3. Tilts the pelvis slightly forward and downward 4. Touches floor first with heel then ball of foot to toes 5. Advances the other arm and leg to promote balance						
	D.	Pulling: 1. Stands close to the object 2. Places one foot slightly ahead of the other. 3. Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscle						
	E.	Pushing: 1. Places hands on object and flexes the elbows. 2. Leans into the object by shifting weight from back let to front leg 3. Applies smooth continuous pressure.						
	F.	Stooping: 1. Stands with feet 10-13 inches apart						

		2. Places one foot slightly ahead of the other 3. Lowers self by flexing the knees 4. Places more weight on front foot than back 5. Keeps upper body straight (does not bend at the waist) 6. Straightens knees keeping the back straight						
	G.	Lifting and Carrying: 1. Assumes stooping position directly in front of the object 2. Grasps objects and tightens abdominal muscles 3. Stands up straight by straightening the knees 4. Carries the object close to the body waist high						

Reference:

National Commission for Health Education Credentialing, Inc. (NCHEC), Society for Public Health Education (SOPHE), American Association for Health Education (AAHE). (2010a).

A competency-based framework for health education specialists - 2010. Whitehall, PA: Author.

http://www.nchec.org/aboutnchec/rc.htm
ETR's Resource Center for Adolescent Pregnancy Prevention
http://www.etr.org/
National Campaign to prevent Teen Pregnancy
http://www.teenpregnancy.org
Adolescent Pregnancy Prevention of North Carolina
http://www.appcnc.org/secondary-navigation/contact

_____ successfully demonstrates the above criteria in the clinical setting.

_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date

The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during initial evaluation and at the time of the annual evaluation.

Date Developed: 2/05
Reviewed: 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/14

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

HIPAA MANUAL
INDEX

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) POLICY

DATE DEVELOPED: **10/02**
REVIEWED: **7/04; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 10/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **7/04; 5/08; 10/13**

I. POLICY:

The Division of Public Health Services will comply with all applicable regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

II. PURPOSE:

The Division of Public Health Services (Agency) is responsible for ensuring the health, safety and well being of the citizens of Rockingham County. The Agency creates and/or maintains individually identifiable health information that is essential for performing routine business operations. The health information created and maintained by our Agency must be protected from misuse and unauthorized disclosure.

The U. S. Department of Health and Human Services (HHS) has issued a new rule called the Final Omnibus rule. This final omnibus rule greatly enhances a patient's privacy protections, provides individuals new rights to their health information, and strengthens the government's ability to enforce the law.

III. GUIDELINES:

The Omnibus Final rule is to: Modify the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and/Enforcement Rules to implement statutory amendments under the Health and Information Technology for Economic and Clinical Health Act of 2009 ("the HITECH Act" or "the Act") to strengthen the privacy and security protection for individuals' health information; modify the rule for Breach Notification for Unsecured Protected Health Information (Breach Notification Rule); modify the HIPAA Privacy Rule to strengthen the privacy protections for genetic information by implementing section 105 of Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA).

A. The Omnibus Rule became effective March 26, 2013 and the compliance date was September 23, 2013.

B. The changes in the final rulemaking:

1. Provide the public with increased protection and control of personal health information.
2. Make business associates of covered entities that receive protected health information, such as contractors and subcontractors, directly liable for compliance with HIPAA Privacy and Security Rules' requirements.
3. Expands the individual rights to receive electronic copies of their health information and it allows restriction of disclosures to a health plan concerning treatment for which the individual has paid out of pocket in full.
4. Sets new limits on how information is used and disclosed for marketing and fundraising purposes and prohibits the sale of an individuals' health information without their permission.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: AGENCY HIPAA PRIVACY/COMPLIANCE OFFICER APPOINTMENTS POLICY

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 7/04; 2/06; 6/14

I. POLICY:

The health care components of the Division of Public Health Services (Agency) complies with all federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The following appointments have been made to implement compliance with the privacy regulations (45.C.F.R.164.500 *et seq.*). The following appointments have been made by the Health Director:

1. Public Health Privacy Officer and Chairperson for the HIPAA Compliance Team is the Staff Development Coordinator.
2. Public Health Compliance Officer is Public Health Director of Nursing.
3. ITS Business Analyst as HIPAA Electronic Privacy Security Compliance Officer.

II. PURPOSE:

To maintain compliance with the privacy regulations issued by the US Department of Health and Human Services (HHS). Agency HIPAA Compliance and Privacy Officers serve as a liaison to regulatory bodies for matters relating to privacy and security. HIPAA Officers collaborate with other designated individuals to ensure policies and procedures relating to (cyber) privacy and security are developed and implemented for the Agency's hardware, software and telecommunications systems. HIPAA Compliance Officers monitor all Agency systems development and operations for security, and privacy compliance. These officers also develop Agency privacy policies and procedures**.**

III. GUIDELINES:

A. The Agency HIPAA Officers are responsible for developing policies and procedures that include but are not limited to:

1. Notice of privacy practices
2. Handling of individually identifiable health information and protected health information (PHI)
3. Use and disclosure of PHI

4. Individual requests for restriction of use and disclosure of PHI

5. Access, inspection, and copying of PHI

6. Accounting of disclosures

7. Record keeping procedures and administrative procedures

B. The HIPAA Privacy Officer is also responsible for:

1. Verification procedures

2. Receiving complaints and/or questions related to any aspect of the Agency's privacy policies

3. Providing information in response to internal and external inquiries regarding the Agency's privacy policies and procedures or Notice of Privacy Practices

4. Recording and documenting all complaints/questions and their resolution

5. Ensuring thorough investigation of all allegations of noncompliance with the Agency privacy policies or Agency Notice of Privacy Practices

6. Reporting on as needed basis the status of the privacy program to the Board of Health and Human Services or other responsible individuals or committees

7. Providing leadership in the planning, design and evaluation of the Agency's privacy and security related projects

8. Developing and implementing an Agency wide privacy training program, which includes:

a. initial training of all employees relating to the privacy and cyber security programs
b. upon changes in Agency privacy policy or procedure, retraining of directly affected employees
c. mandated privacy retraining for all employees on a periodic basis, but at a minimum, every three years
d. privacy training for all members of the workforce, including all employees, trainees, and other persons under the direct control of the Agency, on an unpaid basis, who are not business partners but are likely to have contact with PHI
e. coordinating with the Health Director and other administrative staff to apply sanctions for failure to comply

with the Agency privacy policies and procedures by all members of the Agency's workforce or the Agency's business associates

f. coordinating with the Health Director and administrative staff to ensure no intimidating, discriminatory, or other retaliatory actions occur against a person who files, testifies, assists or participates in any investigation, compliance review, proceeding or hearing related to a privacy violation or opposed any unlawful act or practice

g. implementing and overseeing the development and application of corrective action procedures that are designed to mitigate any detrimental effects of a use or disclosure of PHI by members of the Agency's workforce or business associates

h. establishing an internal privacy audit program to ensure Agency-wide compliance to the privacy policies

i. coordinating the development of privacy risk assessment policies and procedures designated to measure the performance and quality of the Agency's privacy program

j. periodically revising the privacy program in light of changes in laws, regulations or Agency policy

k. coordinating with HIPAA Committee members regarding the development of procedures for consulting with the County Compliance Official and/or the County Legal Department regarding improper disclosures or HIPAA violations, and if appropriate, for reporting violations to the appropriate government regulatory body.

l. providing copies of all required documentation, including any revised forms or policies and procedures, to the Rockingham County Compliance Official within ten business days after the documentation is approved by the Agency HIPAA Committee and Board of Health and Human Services.

C. The Agency HIS Administrator is responsible for:

1. Agency compliance in regards to information technology,

2. Electronic security, and the

3. Development (in conjunction with the IT Department) of firewalls for electronic information to prevent individuals from viewing PHI who do not have a "need to know".

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT RIGHT TO RECEIVE THE *RCDHHS NOTICE OF PRIVACY PRACTICES*

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 7/04; 6/20

I. POLICY:

The health care components of the Division of Public Health Services (Agency) is committed to the protection of individually identifiable health information contained in the designated record sets of the clients it serves. The Agency complies with all federal regulations under HIPAA, and provides each client it serves with a copy of the Agency's *Notice of Privacy Practices,* if requested. The *Notice of Privacy Practices* explains the client's rights regarding protected health information that the Agency maintains on him/her and also explains how the client can gain access to his/her medical information.

II. PURPOSE:

A. To protect the client's right to privacy.

B. To inform clients about their rights under HIPAA.

III. GUIDELINES:

A. Upon initially presenting for services at the Agency or receiving a home visit from staff working with the Family Care Coordination Program, Communicable Disease Program, or any other home visiting or community outreach program on or after April 14, 2003, each current or prospective client shall receive the Agency's *Notice of Privacy Practices.* This document will be distributed by the management support person working in the registration area of the Agency. Clients who are receiving services at their home will receive the document from the nurse or social worker making the visit. The *Notice of Privacy Practices* describes in detail how medical information regarding the client may be used and disclosed. The notice also states how the client can gain access to his/her medical information.

1. The *Notice of Privacy Practices* is available in English and Spanish.

2. Copies of the *Notice of Privacy Practices* in English and Spanish are prominently displayed in the waiting areas and on the Agency's web site. The *Notice of Privacy Practices* is available for download from the Agency's web site.

B. Each client is given a *Terms and Conditions for Our Clients/Acknowledgement of Receipt of Notice of Privacy Practices* form to sign from the management support staff working at the registration window, or by the nurse or social worker making the home visit pursuant to § 164.520(c)(2)(ii) of the HIPAA Regulations acknowledging his/her receipt of the *Notice of Privacy Practices*.

1. The *Terms and Conditions for Our Clients/Acknowledgement of Receipt of Notice of Privacy Practices* form is available in English and Spanish.

2. The *Terms and Conditions for Our Clients/Acknowledgement of Receipt of Notice of Privacy Practices* form is to be scanned under the widget labeled "Consents".

3. The *Terms and Conditions for Our Clients/Acknowledgement of Receipt of Notice of Privacy Practices* form is updated annually.

C. In an emergency treatment situation, the *Notice of Privacy Practices* is to be provided to the individual as soon as reasonably practicable after the emergency treatment situation.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ACCOMMODATION OF CLIENT RIGHT TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

DATE DEVELOPED: 3/31/03
REVIEWED: 2/06; 3/07; 1/08; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 7/04; 1/08

I. POLICY:

The covered health care components of the Division of Public Health Services (Agency) comply with all federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and as permitted by HIPAA, accommodates requests for access to protected health information (PHI) contained in designated record sets of the clients it serves. An individual, as the verified legal representative of a client, may also request access to PHI contained in a designated record set.

II. PURPOSE:

To establish a protocol for employees of the Agency to follow for accommodating an individual's (the term "individual" refers to the client or to a verified legal representative) request for access to PHI.

III. GUIDELINES:

A. General Rule: Except as provided in §§ 164.524(a)(2) or (a)(3) the Agency must provide access to PHI in designated record sets. Providing "access" means that the Agency must comply with an individual's request to:

1. Inspect their PHI, and/or

2. Receive a copy of their PHI.

B. The Agency must provide the individual with access to PHI in the form or format requested by the individual if it is readily producible in such form or format. If it is not readily producible in such format, the Agency must provide access in:

1. A readable hard copy form, or

2. Any other form or format agreed to by the Agency and the individual.

C. In lieu of providing direct access to PHI, the Agency may provide an individual with a summary of the PHI requested if:

1. The individual agrees in advance to the summary, and

2. The individual agrees in advance to fees (if any) that the Agency may charge for preparing the summary.

D. If the Agency provides access to PHI, the Agency may also provide an individual with an explanation of the PHI if:

1. The individual agrees in advance to the explanation, and

2. The individual agrees in advance to fees (if any) that the entity may charge for preparing the explanation.

E. The Agency may discuss the scope, format and other aspects of the request for access with the individual, if necessary, to ensure that the individual obtains access in a timely fashion. The Agency must provide access within the required time frames, which may include either arranging with the individual for a convenient time and place to inspect or obtain a copy of the PHI or mailing the PHI to the individual at the individual's request.

F. The Agency may charge a reasonable, cost-based fee for a copy of the PHI, a summary of the PHI, or an explanation of the PHI. The fee may only include the cost of:

1. Copying – this includes the cost of supplies and labor of copying.

2. Postage (when the individual has requested the information be mailed), and

3. Preparation of a summary or an explanation, if agreed to by the client. (See C and D above.)

G. When an individual requests access to PHI, the individual shall be referred to the Agency's Processing Assistant V, or to the Agency's Privacy Officer. In conjunction with these individuals, the record will be reviewed by program-specific Agency staff to determine what information contained within the record will be disclosed.

H. The individual will be provided with a *Client Information Request Form* and assisted in the completion of the *Access Request Form* portion.

1. The individual is informed verbally by the Processing Assistant V or by the Agency's Privacy Officer that the Agency has 30 days to respond to the request. This time frame can be extended to up to 60 days if the PHI being requested is located off site. §§164.524(b)(2).

2. The individual is informed by the Processing Assistant V or the Agency's Privacy Officer that he/she will receive notification regarding the status of the request once it is reviewed by the Privacy Officer and/or the Processing Assistant V.

3. Completed copies of the *Client Information Request Form* are distributed as follows:

    a. One is given to the individual
    b. A copy is placed under the "Consent" index of the client's medical record.
    c. The original is retained by the Processing Assistant V or the Privacy Officer depending on which designated staff member is responding to the request.

4. *The Response to Request for Access or Copying of PHI Form* is used to notify the individual of the outcome of the request. A copy of this form will be placed in the client's medical record under the "Consent" index tab on the left side of the medical record.

I. If access is permitted in whole or in part, the Agency shall inform the individual of the right to obtain a copy of the PHI by paying a nominal fee or inform the individual that he/she may personally inspect the record at a time convenient to the individual and the Agency during normal business hours. Once payment of the fee is received, the copy of the PHI requested by the client can be mailed at the client's request.

J. If access cannot be accommodated in whole or in part, the individual shall be notified by telephone and by mail. It is important to note that the privacy rule *does not require* the Agency to deny a request for access on any grounds. US HHS intended to create narrow exceptions to the right of access and HHS expects the Agency to deny access rarely. The preamble to the privacy rule states the Agency "may provide all the information requested or evaluate the requested information, consider the circumstances surrounding the individual's request, and make a determination as to whether the request should be granted or denied, in whole or in part, in accordance with one of the reasons for denial under [the privacy rule.]"65

Fed. Reg. at 82,556. The Privacy Officer or the Processing Assistant V will document on the *Response to Request for Access Form* or *Copying of PHI Form*, that either,

1. The individual was denied access with *no right of review*. The reason for the denial is indicated on the form. These grounds are un-reviewable. Access can be denied for the following PHI:

    a. Psychotherapy notes, such as notes that are recorded by a health care provider who is a *mental health professional* and include: notes that are recorded documentation or analysis of the content of a conversation during a private counseling session or a group, joint, or family counseling session; *notes that are separated from the rest of the individual's medical record*.

        i. information *excluded* from the term "psychotherapy notes" and *not* considered psychotherapy notes includes: medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following:
            - functional status
            - treatment plan
            - symptoms
            - prognosis, and
            - progress to date.

    b. Information compiled in reasonable anticipation of, or in use in, a civil, criminal, or administrative action or proceeding. This includes any information that relates specifically to legal preparations but not to the individual's underlying health information.

    c. PHI maintained by the Agency that is subject to the Clinical Laboratory Improvements Amendments of 1988 (CLIA) pursuant to 42 C.F.R. § 493.3(a)(2).

    d. Requests for PHI that are subject to the Privacy Act of 1974 (5 U.S.C.§ 552a), may be denied if the denial of access under the Privacy Act would meet the requirements of that law and applies to records about individuals that are:

        i. maintained by federal executive agencies, and

ii. contained in a "system of records" (which is, in general, a group of records from which an agency retrieves information about an individual by using an identifier such as a name, number, etc.)

e. A request for access may be denied if there has been a "promise of confidentiality".

i. the individual requests access to PHI that was obtained from someone other than a health care provider under a promise of confidentiality, and
ii. the access requested would be reasonably likely to reveal the source of the information.

f. A request for access will be denied if every individual whose information will be disclosed has not authorized its release. Alternatively, a request may be granted after the Agency has redacted information pertaining specifically to other individuals within the requested record.

2. <u>*Reviewable Denial*</u>: The client is denied access but can request that the denial be reviewed. These forms of denial include:

a. Likely to Endanger – the Agency may deny an individual's request for access if a licensed professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person. The Agency *may not* deny access only on the basis of the sensitivity of the health information or the potential for causing emotional or psychological harm. The denial is linked exclusively to the likelihood of endangering *life* or *physical safety*.
b. Reference to Another Person – the Agency may deny an individual's request for access if:

i. the PHI makes reference to another person (unless such person is a health care provider), and
ii. a licensed health care professional has determined in the exercise of professional judgment that the access requested is reasonably likely to cause substantial harm to such other person.

c. Personal Representative – the Agency may deny an individual's request for access if:

i. the request for access is made by the individual's personal representative, and
ii. a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access is reasonably likely to cause substantial harm to the individual or another person.

d. Personal Representative – The Agency may elect to not treat a person as a personal representative if the following two criteria are satisfied:

i. the Agency has a reasonable belief that –
(1) the individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or
(2) treating such person as the personal representative could endanger the individual; and
ii. the Agency, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's representative.

3. The following steps must be followed for a reviewable denial:

a. The Agency must designate a licensed health care professional who was <u>not</u> directly involved in the initial denial to review the denial. The term "licensed health care professional" is not defined in the privacy rule, but US HHS provided as examples to the term "a physician, physician's assistant, or nurse".
b. The Agency must promptly refer a request for review to the designated professional.
c. The designated professional must determine, within a reasonable period of time, whether or not to deny the access requested based on the standards set forth in § 164.530(a)(3) and in (III)(J)(2)(a, b, c) of this policy, as stated above.
d. The Agency must promptly provide written notice to the individual of the determination of the designated professional.

K. Implementation specifications for denial of access. If the Agency denies access, in whole or in part, to PHI, the Agency must comply with the following requirements:

1. The Agency must, to the extent possible, give the individual access to any other PHI requested, after excluding the PHI as to which the Agency has a ground to deny access.

2. The Agency must provide a timely, written denial to the individual, in accordance with section III (J) of this policy. The denial must be in plain language and contain:

   a. the basis for the denial
   b. if applicable, a statement of the individual's review rights under section III (J) of this policy, including a description of how the individual may exercise such review of rights; and
   c. a description of how the individual may complain to the Agency pursuant to the complaint procedures in § 164.590(d) or to the Secretary pursuant to the procedures in § 160.306. The description must include the name or title and telephone number of the contact person or office designated in § 164.530(a)(1)(ii).

      i. this information is located in the Agency's *Notice of Privacy Practices*
      ii. this information is located on the Agency form titled *Response to Request for Access or Copying of Protected Health Information*

3. If the Agency does not maintain the PHI that is the subject of the individual's request for access, and the Agency knows where the requested information is maintained, the Agency must inform the individual where to direct the request for access.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT RIGHT TO AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION POLICY

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 7/05; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16

I. POLICY:

The covered health care components of the Division of Public Health Services (Agency) comply with all federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and as permitted by HIPAA, accommodate client requests for an accounting of disclosures of protected health information (PHI) contained in the designated record sets of the clients it serves. An individual, as the verified legal representative of a client, may also request an accounting of disclosures of PHI contained in a designated record set. Refer to Designated Record Set Policy.

II. PURPOSE:

A. US HHS identified two basic purposes for establishing the right to an accounting of disclosures: "It provides a means of informing the individual as to which information has been sent to which recipients. This information, in turn, enables individuals to exercise certain rights under the rule, such as the rights to inspection and amendment, with greater precision and ease. The accounting also allows individuals to monitor how covered entities are complying with the rule." 65 Fed.Reg. At 82,739.

B. The purpose of this policy is to establish a protocol for employees of the Agency to follow for accommodating client requests for an accounting of disclosures of PHI made by the Agency in the six years prior to the date of the client's request (but no earlier that the compliance date for the privacy rule). The client may request an accounting for less than six years. § 164.528(a).

III. GUIDELINES:

A. Certain disclosures are *not* required to be included in the accounting. Specifically, excepted disclosures are those:

1. That occurred prior to the privacy rule compliance date;

2. To carry out treatment, payment or health care operations;

3. To the individual who is the subject of the PHI;

4. Made incident to a use or disclosure otherwise permitted or required by the privacy regulation as provided in § 164.502;

5. Pursuant to an authorization as provided in § 164.508;

6. For a facility directory or to persons involved in the client's care or other notification purposes as provided in § 164.510;

7. To individuals involved in the client's care (such as family, friends, or in disaster relief situations);

8. For national security or intelligence purposes as provided in § 164.512(k)(2); and

9. To correctional institutions or law enforcement officials when the disclosure is consistent with § 164.512(k)(5);

10. Made as part of a limited data set in accordance with § 164.514(e).

B. The Agency *must* temporarily suspend a client's right to receive an accounting if:

1. The disclosure is to a health oversight agency or law enforcement official (as permitted by the privacy rule); and

2. The (oversight) agency or (law enforcement) official provides the Agency with written or oral statement explaining that an accounting to the individual would be reasonably likely to impede the (oversight) agency's activities and specifying the time for which the suspension is required.

   a. If the above statement is written, the Agency must temporarily suspend the individual's right for a period of time specified by the (oversight) agency or (law enforcement) official.
   b. If the above statement is oral, the Agency must:

      i. document the statement (including the identity of the oversight agency or law enforcement official); and
      ii. temporarily suspend the client's right for no longer than 30 days, unless a written statement is submitted during that time.
      iii. limit the temporary suspension to no longer than 30 days from the date of the oral statement, unless a written statement is submitted during this time.

3. An individual may request an accounting of disclosure for a period of time less than 6 years from the date of the request.

C. The content of the accounting of disclosures includes:

1. Disclosures of the PHI that occurred during the six years prior to the date of the request for an accounting, including disclosures to or by business associates of the covered entity.

2. The following required elements for each disclosure:

   a. The date of the disclosure;
   b. The name of the entity or person who received the PHI, and, if known, the address;
   c. A brief description of the PHI disclosed; and
   d. Either:

      i. a brief statement of the purpose of the disclosure that reasonably informs the client of the basis of the disclosure;
      ii. a copy of any written request for disclosure by US HHS for compliance purposes; and
      iii. a copy of any written request for disclosure by a person or entity authorized to receive PHI for national priority uses and disclosures under § 164.512 (such as public health authority, health oversight agency, law enforcement official, researcher, etc.).

D. If the Agency made multiple disclosures of PHI to the same person or entity for a *single purpose* either to US HHS for compliance purposes or to a person or entity authorized to receive PHI for national priority uses and disclosures under § 164.512, the accounting may include:

1. All of the required elements described above (III (C)(2) of this policy) for the first disclosure;

2. The frequency, periodicity, or number of the disclosures made during the accounting period; and

3. The date of the last such disclosure during the accounting period.

E. Procedural requirements applicable to the right to an accounting:

Individual request: The privacy rule does not explicitly permit the Agency to require the client to put the request in writing. The rule does not, however, prohibit the Agency from asking the individual to put the request in writing.

1. Clients requesting an accounting of disclosures of PHI are to be assisted in completing an *Accounting of Disclosures Request*, found on the *Client Information Request Form*.

2. The client is to be informed that the Agency must act on a request for an accounting no later than 60 days after receipt of the request §164.528(c)(1). *"Acting on a request,"* means as follows:

   a. provision of accounting: the Agency must provide individual with the accounting; or
   b. extension: if the Agency is unable to act on a request within the 60-day time frame, the Agency may grant itself a *single* extension of no more than 30 days. In order to take such an extension, the Agency must (within the original 60-day period) provide the client with a written statement explaining the reasons for the delay and the expected date by which the Agency will be able to fulfill its responsibilities. No additional extensions are permitted.

F. Fees

1. The Agency must provide the first accounting to a client in any 12-month period without charge.

2. Subsequent requests:

   a. General rule: If a client requests one or more additional accountings within the same 12-month period, the Agency may charge a reasonable cost-based fee for each one.
   b. Conditions: The Agency may only charge a fee if it:

      i. informs the individual in advance of the fee; and
      ii. provides the client with an opportunity to withdraw or modify the request in order to avoid or reduce the fee.

G. Documentation

1. General rule: The Agency must develop and retain the following documentation (in written or electronic form):

   a. The information required to be included in the accounting ("required elements", III(C)(2) of this policy) for disclosures that not excepted (III(A) of this policy) from the right to an accounting;
   b. Any written accounting that is provided to an individual; and
   c. Identification of the title of the person(s) or office(s) responsible for receiving and processing requests for an accounting. §§ 164.526(f); 164.530(d):

      i. Medical Records Supervisor; or
      ii. Privacy Officer.

2. Retention period: The Agency must retain the documentation for six years from the *later* of:

    a. The date of its creation; or
    b. The date when it last was in effect.

3. Exceptions that do not need to be accounted for on the *Client Information Tracking Form* includes the following:

    a. Those required by law - § 164.512(a)
    b. Those required for public health activities. This also encompasses release of PHI to public health authorities, FDA officials and employers - § 164.512(b)
    c. Victims of abuse § 164.512(c)
    d. Health oversight activities § 164.512(d)
    e. Judicial and administrative proceedings - § 164.512(e)
    f. Law enforcement purposes - § 164.512(f)
    g. Disclosures about decedents (including medical examiners and funeral directors) - § 164.512 (g)
    h. Disclosures for organ donation purposes - § 164.512(h)
    i. Disclosures for research - § 164.512(i)
    j. Disclosures to avert a serious threat to health or safety - § 164.512(j)
    k. Disclosures for specialized government functions - § 164.512(k)
    l. Disclosures for workers' compensation - § 164.512(l)
    m. Disclosures made to business associates - § 164.502 and § 164.528(a)(l)(iii)
    n. To carry out treatment, payment, and health care operations - § 164.506
    o. When provided to the individual - § 164.528(a)(l)(ii)
    p. When an authorization is provided as described in § 164.508 - §164.528(a)(l)(iv)
    q. National security purposes as in § 164.512(k)(2) - § 164.528(a)(l)(vi)
    r. Provided to law enforcement as provided in § 164.512(k)(5) - § 164.528(a)(l)(vii)
    s. As part of a limited data set in accordance with § 164.512(e) - § 164.528(a)(l)(viii)
    t. That occurred prior to the compliance deadline (04-14-03) - §164.528(a)(l)(ix)

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT RIGHT TO REQUEST AMENDMENT OF PROTECTED HEALTH INFORMATION

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 7/05; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 7/05

I. POLICY:

The covered health care components of the Division of Public Health Services (Agency) comply with all federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and as permitted by HIPAA, accommodate requests for amendment of protected health information (PHI) contained in the designated record sets of the clients it serves. An individual, as the verified personal representative of a client, may also request that PHI contained in a designated record set be amended. Amended PHI received from covered entities outside of the Agency will be inserted into the client's designated record set and utilized to provide continuity of care for that client.

II. PURPOSE:

A. US HHS explains that the "purpose of this provision is to create a mechanism whereby individuals can ensure that information about them is as accurate as possible as it travels through the health care system and is used to make decisions, including treatment decisions, about them." 65 Fed. Reg. at 82,736. The term, "individual," refers to the client or to a verified personal representative for the purpose of this policy.

B. The purpose of this policy is to establish a protocol for employees of the Agency to follow for accommodating an individual's request to amend PHI.

C. Amended PHI received from a covered entity located outside of the Agency and serving the same client will be inserted into the client's designated record set and will be utilized to provide continuity of care for that client.

III. GUIDELINES:

A. An individual has a right to have the Agency amend PHI or a record about the individual maintained in a designated record set § 164.526(a).

B. The Agency may deny a request for amendment if it determines that the PHI or record that is the subject of the request:

1. Was not created by the Agency, unless the individual provides a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
2. Is not part of the designated record set;
3. Would not be available for inspection under § 164.524; or
4. Is accurate and complete.

C. The Agency must permit an individual to request that the Agency amend the PHI maintained in a designated record set. The Agency may require individuals to make requests for amendment in writing and to provide a reason to support a requested amendment, provided that it informs individuals in advance of such requirements.

D. The Agency must act on the individual's request for an amendment no later than 60 days after receipt of such a request, as follows:

1. If the Agency grants the requested amendment, in whole or in part, it must take the actions required by section III (F) of this policy.
2 If the Agency denies the requested amendment, in whole or in part, it must provide the individual with a written denial as required by section III (G) of this policy.

E. If the Agency is unable to act on the amendment within the time required, the Agency may extend the time for such action by no more than 30 days, provided that:

1. The Agency, within the time limit set by section III (D) of this policy, provides the individual with a written statement of the reasons for the delay and the date by which the Agency will complete its action on the request; and
2. The Agency may have only *one* such extension of time for action on a request for amendment.

F. If the Agency accepts the requested amendment, in whole or in part, the Agency must comply with the following requirements:

1. The Agency must make the appropriate amendment to the PHI or record that is the subject of the request for amendment by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.
2. In accordance with this policy, the Agency must inform the individual in a timely manner that the amendment is accepted**,** and obtain the individual's identification of and agreement to have the Agency notify the relevant

persons with which the amendment needs to be shared in accordance with section III (F)(3) of this policy.

3. The Agency must make reasonable efforts to inform and provide the amendment within a reasonable time to:

    a. Persons identified by the individual as having received PHI about the individual and needing the amendment; and
    b. Persons, including business associates, that the Agency knows have the PHI that is the subject of the amendment and that may have relied, or could forseeably rely, on such information to the detriment of the individual.

G. If the Agency denies the requested amendment, in whole or in part, the Agency must comply with the following requirements:

1. The Agency must provide the individual with a timely written denial, in accordance with section III (D) of this policy. The denial must use plain language and contain the following:

    a. The basis for the denial, in accordance with section III (B) of this policy;
    b. The individual's right to submit a written statement disagreeing with the denial and how the individual may file such a statement;
    c. A statement that, if the individual does not submit a statement of disagreement, the individual may request that the Agency provide the individual's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment; and
    d. A description of how the individual may complain to the Agency pursuant to the complaint procedures established in § 164.530(d) or to the Secretary pursuant to the procedures established in § 160.306. The description must include the name, or title and telephone number of the contact person or office designated in § 164.530(a)(1)(ii).

2. The Agency must permit the individual to submit to the Agency a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. The Agency may reasonably limit the length of a statement of disagreement.
3. The Agency may prepare a written rebuttal to the individual's statement of disagreement. Whenever such a rebuttal is prepared, the Agency must provide a copy to the individual who submitted the statement of disagreement.

4. The Agency must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed amendment, and append or otherwise link the individual's request for amendment, the Agency's denial of the request, the individual's statement of disagreement, if any, and the Agency's rebuttal, if any, to the designated record set.
5. Regarding future disclosures of information that is the subject of the disputed amendment:

    a. If a statement of disagreement has been submitted by the individual, the Agency must include the material appended in accordance with section III (G)(4) of this policy, or, at the election of the Agency, an accurate summary of any such information, with any subsequent disclosure of the PHI to which the disagreement relates.
    b. If the individual has not submitted a written statement of disagreement, the Agency must include the individual's request for amendment and its denial, or an accurate summary of such information, with any subsequent disclosure of the PHI only if the individual has requested such action in accordance with section III (G)(1)(c) of this policy.
    c. When a subsequent disclosure described in section III (G)(5)(a) or (b) of this policy is made using a standard transaction that does not permit the additional material to be included with the disclosure, the Agency may separately transmit the material required in section III (G)(5)(a) or (b) of this policy, as applicable, to the recipient of the standard transaction.

H. If our Agency is informed by another covered entity of an amendment to an individual's PHI, in accordance with section III (F)(3) of this policy, our Agency must amend the PHI in the individual's designated record set as provided in section III (F)(1) of this policy.

I. The Agency must document the titles of the persons or offices responsible for receiving and processing requests for amendments by individuals and retain the documentation as required by § 164.530(j).

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT RIGHT TO REQUEST RESTRICTIONS ON THE USE AND DISCLOSURE OF PHI; CONFIDENTIAL COMMUNICATIONS

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 7/05; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 7/05; 6/24

I. POLICY:

The health care components of the Division of Public Health Services (Agency) comply with all federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and accommodate client requests for additional restrictions and protections of the use and disclosure of protected health information (PHI).

II. PURPOSE:

A. To establish a protocol for employees of the Agency to follow for accommodating client requests to restrict the use and disclosure of PHI, as well as requests relating to confidential communications between the Agency and the client. (Refer to Minimum Necessary Policy)

B. Definitions for terms used in this policy include:

1. *Protected Health Information* (PHI) means individually identifiable health information relating to past, present, or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual transmitted or maintained in any form (i.e., paper, electronic).
2. *Designated Record Set* means a group of records, maintained by or for the Agency, that include medical, billing, enrollment, payment, claims adjudication, and other records used to make decisions about an individual.
3. *Personal Representative* means a person who has verified authority under applicable law to make decisions related to health care on behalf of an adult or an emancipated minor, or the parent, guardian, or other person acting in *loco parentis* who is authorized under law to make health care decisions on behalf of an unemancipated minor, except where the minor is authorized by law to consent, on his/her own behalf or via court approval, to a health care service, or where the parent, guardian, or person acting in *loco parentis* has assented to an agreement of confidentiality between the provider and the minor.
4. *Business Associate* (BA) means a person or entity who, on behalf of the Agency, or a health care component of the Agency, but not in the capacity

of a workforce member, performs, or assists in the performance of, a function or activity involving the use or disclosure of PHI, or provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services involving disclosure of PHI.

5. *Privacy Notice* means the notice of privacy practices relating to an entity's use and disclosure of PHI that is mandated under HIPAA regulations for distribution to all individuals whose information will be collected by or on behalf of the entity.

III. GUIDELINES:

A. The Agency must permit an individual to request that the Agency restrict certain uses and disclosures.

B. The Agency may accommodate any client's (or his verified personal representative) *reasonable* request that the Agency restrict uses and disclosures of PHI made for treatment, payment or health care operations (TPO) or disclosures to family or others involved in the client's care. The Agency *does not* have to agree to the restriction requested.

1. The Clinical Record's Supervisor and/or the Agency's Privacy Officer must evaluate the "reasonableness" of the request only on the basis of the administrative difficulty of complying with the request. US HHS explains that "what is reasonable may vary by the size or type of Agency, however, additional modest cost to the Agency would not be unreasonable" 65 Fed. Reg. At 82,729.
2. When a client submits a request, the Agency's clinical records staff *may not* inquire about or seek an explanation from the client as to the basis for the request as a condition of accommodating the request.

C. The Agency must accommodate a client's (or his verified personal representative) *reasonable* request that the Agency use an alternative location from his home address and/or alternative means to contact the client. US HHS explains that the requirement applies to "communications from the Agency to the individual, and also communications from the Agency that would otherwise be sent to the named insured of an insurance policy that covered the individual as a dependent of the named insured." 65 Fed. Reg. At 82,553. For example:

1. Alternative location: A client may request to receive all written communications from the Agency at a work address rather than a home address.
2. Alternative means: A client may request that the Agency never contact her by phone, but rather always via mail or email.

D. When a client submits such a request, the Agency and the Agency's business associates must accommodate the request if the request is *reasonable*. The Clinical Records supervisor and/or the Agency's Privacy Officer may evaluate the "reasonableness" of the request only on the basis of the administrative difficulty of complying with the request. US HHS explains that "what is reasonable may vary by the size or type of covered entity; however, additional modest cost to the provider would not be unreasonable."

The Agency may not require an explanation from the client. When a client submits a request, members of the staff workforce *may not* request an explanation from the client as to the basis for the request as a condition of accommodating the request.

E. The Agency may place certain conditions on accommodating such requests. § 164.522(b)(2).

1. The Agency may require that the individual submit the request in writing.
2. If appropriate under the circumstances, the Agency may condition its decision to accommodate the request on information as to how payment (if any) will be handled.
3. The Agency may condition its decision to accommodate the request on the client providing an alternative address or other method of contact.

   For example: If a client requests that all communications be sent to a work address, the Agency may condition its decision on whether the client provides an accurate work address.

F. The Privacy Rule does not explicitly permit the Agency to require the client to put a request to limit use and disclosure of PHI in writing. The rule does not, however, prohibit the Agency from asking the client to put the request in writing.

G. The Privacy rule requires that the Agency document an agreed upon restriction. US HHS explains that the "writing need not be formal; a notation in the clinical record will suffice" 65 Fed. Reg. At 82,728. This information will be documented **in an EHR note or note screen**.

H. It is clear that if a client makes an oral request for a restriction and the Agency agrees to the request, the agreement is then binding until terminated. US HHS explains that the agency does not believe that an agreed upon restriction must be reduced to writing to be enforceable. 65 Fed. Reg. At 82,728. Once the restriction is agreed to orally, the Agency has the duty to document it but the Agency's failure to document it does not release the Agency from its duty to comply with the agreement.

I. If the Agency agrees to a requested restriction, the Agency and its business associates may not use or disclose PHI in violation of the agreement. In other words, once the Agency agrees to a request, it is bound by the restriction for all future use and disclosure of the PHI until the agreement is terminated.
Exceptions:

1. Emergency treatment: The Agency may disclose the restricted PHI to a health care provider providing emergency treatment if:

   a. the client who requested the restriction is in need of emergency treatment; and
   b. the PHI is needed to provide emergency treatment.

2. Subsequent use or disclosure: If the Agency discloses PHI to a provider under the emergency treatment exception described above, the Agency must request that the provider not further use or disclose the PHI.

J. After agreeing to a restriction, the Agency is neither prohibited nor required to notify subsequent recipients of PHI that the PHI is subject to restriction. US HHS "encourage(s) covered entities to inform others of the existence of a restriction, in accordance with professional practice and ethics, when appropriate to do so." HHS cautions entities to "carefully consider whether disclosing the existence [of a restriction]" ultimately results in a disclosure of the PHI. 65 Fed. Reg. 82,729. For example, if the covered entity is an HIV/AIDS clinic and it has agreed not to disclose PHI for payment purposes, any communication between the clinic and the individual's insurer, even if it is simply the clinic responding that it has agreed to a restriction, will strongly suggest that the individual is being treated for HIV/AIDS.

K. An agreed upon restriction may never prevent the following uses or disclosures:

1. Uses or disclosures to US HHS for compliance purposes;
2. Uses or disclosures from facility directories (consistent with § 164.510(a));
3. Uses or disclosures for which an opportunity to agree or object is not required including national priority uses and disclosures, such as public health, law enforcement, and research (consistent with. § 164.512).

L. The Agency must retain the documentation **per EHR requirements.**

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CONFIDENTIALITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION POLICY

DATE DEVELOPED: **9/94**
REVIEWED: **6/96; 5/00; 2/01; 5/01; 1/03; 5/03; 2/04; 7/04; 10/04; 4/05; 05/05; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/96; 5/00; 2/01; 5/01; 1/03; 5/03; 2/04; 10/04; 4/05; 5/05; 6/15; 6/17; 6/22; 6/24**

I. POLICY:

The health care components of the Division of Public Health Services (Agency) are committed to the protection of confidential health information contained in the designated record sets of the clients it serves. The Agency complies with all federal regulations under HIPAA, and will not use or disclose individually identifiable health information without the client's authorization to any third party, unless the use or disclosure is pursuant to Privacy Rule § 164.512 that allows the use or disclosure, without authorization or consent, under certain specified circumstances, or the use or disclosure is for treatment, payment or health care operations pursuant to § 164.506.

II. PURPOSE:

A. To protect the client's right to privacy and prevent the unauthorized use or disclosure of individually identifiable health information, except as allowed by law.

B. To educate staff regarding HIPAA Regulations relating to confidentiality of individually identifiable health information. To prevent the imposition of civil and criminal penalties on the County, the Agency and its employees for violation of HIPAA Regulations relating to the confidentiality of PHI.

III. GUIDELINES:

A. *Individually identifiable health information (IIHI)* is data that includes demographic information, and information that relates to past, present or future physical, or mental health or a condition of the individual. It also includes information that is collected regarding the client that is used in the provision of health care to the individual or information that is used for the past, present or future payment for the provision of health care to an individual. Individually identifiable information also includes information that identifies the individual or to which there is a reasonable basis to believe the information can be used to identify the individual.

B. *Protected health information* (PHI) is individually identifiable health information that is:

1. Transmitted by electronic media.

2. Maintained in any medium or electronic media.

3. Transmitted or maintained in any other form or medium.

C. *Agency Workforce* means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for the Agency, is under the direct control of the Agency, whether or not they are paid by the Agency.

D. Individually identifiable health information is considered confidential. This data is of a personal and private nature and is communicated in confidence under circumstances that imply that it shall not be divulged by the recipient of such information except as allowed by law. It is accepted by all health care providers that information contained in the medical record is personal and private and is, therefore, confidential.

E. All Agency employees are required to sign a Confidentiality Statement upon employment and annually thereafter as a part of their yearly evaluation.

F. Incidental disclosures occur when PHI is disclosed inadvertently even when precautions are taken, and procedures have been followed. HIPAA recognizes that incidental disclosures may occur**.** The circumstances of the disclosure will determine if mitigation is required**.**

G. Violations of the Agency HIPAA Confidentiality Policy or of any other Agency or County policy, procedure or guideline will be dealt with pursuant to the *Rockingham County Personnel Policy Handbook* (**Policy 7).**

H. A blatant, deliberate violation of the Confidentiality Policies of the Agency or County may result in immediate termination of the employee as well as the possible imposition of civil and/or criminal penalties.

I. Individually identifiable health information, including protected health information, encompasses any and all information received by the Agency about a client or prospective client, and is considered private and confidential. This may include, but is not limited to:

1. Medical records including demographic information.

2. Billing information.

3. Client specific care plans.

4. Infection control, risk management and/or quality assessment reports.

5. Verbal communication between the client and staff or between staff members.

6. The fact that a client is even a client of the Agency is considered confidential.

J. All members of the Agency's workforce shall:

1. Follow all Agency Policies and Guidelines.

2. Follow the terms specified in the Confidentiality Statement.

3. Maintain medical records in a lockable area:

   a. medical records room
   b. locked file cabinet

4. Limit access to PHI to staff working in the medical record room and staff working in program areas.

5. Prevent access to medical records by unauthorized individuals in community areas of the building by not leaving medical records unattended in the following areas:

   a. Waiting areas
   b. Hallways
   c. Conference rooms, mailrooms
   d. Examination rooms

6. Securely maintain medical records within the Agency at all times, except as noted in item #8.

   a. Return all files with PHI to the Medical Records Room or to the locked file cabinet when leaving the work area.
   b. Cover paperwork with PHI located on assigned desks whenever leaving the area.

7. Return client records to the Medical Records Room as soon as documentation is complete.

8. Place client records that are transported for physician signatures in a secured container in the trunk of the car, or behind the passenger seat in vehicles without a trunk. Lock the vehicle as an additional safeguard. Records shall only be transported by supervisors or designee.

9. Attach and fax a "confidentiality cover sheet" with any faxed information regarding PHI. A confidential cover sheet shall identify the information being transmitted as individually identifiable health information.

   Staff shall verify and identify the fax telephone number is that of the correct authority requesting the PHI prior to transmission for compliance with Privacy Rule 45 C.F.R. § 164.514 (h) by phoning the entity and verifying that the number is correct, and notifying the entity that confidential information is forthcoming via fax.

10. All triage staff can access the fax emails with the link. Faxes remain secure and are shredded after information is no longer needed or scanned into the EHR.

11. Destroy all documents with PHI by shredding prior to being discarded in the trash. Only destroy documents in accordance with (a) and (b). (Examples: extra labels, hand written clinic notes used for dictation in the clinical medical record, etc.)

    a. Refer to the Medical Records Retention policy in the *Record Retention and Disposition Manual* located in the Director of Nursing's office.
    b. HIPAA regulations require that medical records and documentation must be retained for a minimum of six years.

12. Secure a release of information form for all information copied from the record and follow Agency policy for "Release of Information".

13. Members of the Agency workforce ***do not*** **have to record a disclosure** if it falls under one of the following categories:

    a. A disclosure for treatment, payment or health care operations, of minimum necessary information to any entity

or person outside of the Agency, as provided in § 164.506. The General Assembly amended a state confidentiality law, G.S. 130A-12, to authorize health departments to disclose information for purposes of treatment, payment, and health care operations [S.L. 2004-80, (S 582)]. Such disclosures are further restricted by HIPAA and other state law, but this amendment assures local health departments that they may disclose most health information for these three purposes in most situations without written permission.

At least two exceptions apply. State regulations require health departments to obtain written permission to bill a third party payer for HIV testing or counseling and disclose HIV/AIDS-related information for treatment purposes when the department has *not* provided direct medical care to the client. 10A NCAC 41A .0202(9) and (11).

b. A disclosure to the client, who is the subject of the PHI, as provided in § 164.502.
c. A disclosure made incidental to a use or to a disclosure otherwise permitted or required, by the privacy regulation.
d. Pursuant to an authorization, as provided in § 164.508.
e. A disclosure that is used for an Agency directory or to individuals involved in the client's care or for other notification purposes, as provided in § 164.510.
f. A disclosure made for national security or intelligence purposes, as provided in § 164.512 (k)(2).
g. A disclosure made to correctional institutions or law enforcement officials, as provided in §164.512 (k)(5).
h. A disclosure made as part of a limited data set, in accordance with § 164.514 (c).
i. A disclosure that occurred prior to April 14, 2003.

14. Position computer monitor screens to provide maximum privacy of PHI, and never leave your monitor or work station unattended with client information in plain view. Utilize screen savers or lock computer by using "windows" symbol and "L" key on the computer keyboard or log off if you leave the area. Computer passwords will be changed on a regularly scheduled basis to maintain confidentiality and limit access to PHI based on IT prompting.

15. Discussion or the sharing of PHI with individuals who have no need to know is not allowed, and is a violation of client confidentiality. If a member of the Agency workforce has a need to discuss PHI with

another employee with a "need to know", the PHI should be discussed quietly and out of hearing distance of other clients or individuals. "Need to know" refers to necessary and appropriate to carry out job functions.

16. The use of Telecommunications Relay Services (TRS) between Agency staff and clients, when one of the parties has a hearing or speech disability, does not violate the HIPAA Privacy Rule and does not require the Agency to enter into a business associate agreement with the TRS facility as stated in a decision jointly made by the FCC and the US HHS.

17. An authorization is not required when an interpreter is used to communicate with a client, when the Agency (which is also subject to Title VI of the Civil Rights Act of 1964) meets the following requirements:

    a. When the interpreter is a member of the workforce staff as defined at 45CFR 160.103;
    b. When the interpreter is a family member, close friend, or any other person identified by the client as his or her interpreter for a particular healthcare encounter as defined by 45 CFR 164.510(b)(2);
    c. Whenever using a telephone interpreter service to communicate with a client. The interpreter may explain to the client that the interpreter is available to assist the client in communicating with the provider. If the provider reasonably concludes that the client has chosen to be assisted by the interpreter, and, by the client's willingness to continue the health care encounter using the interpreter, reasonably infers that the client does not object to the disclosure, PHI may be disclosed in accordance with 45 CFR 164.510(b) without a business associate contract.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MINIMUM NECESSARY MEDICAL INFORMATION POLICY

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 7/04; 3/10; 6/17

I. POLICY:

The health care components of the Division of Public Health Services (Agency) are subject to compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

II. PURPOSE:

A. The purpose of this policy is to set forth the requirements for making reasonable efforts to limit the use and disclosure of *individually identifiable health information* (IIHI) and/or *protected health information* (PHI) to that which is minimally necessary. The Agency will also follow the minimum necessary principle when requesting PHI from another covered entity.

B. Definition of terms used in this policy include:

1. *Use* which means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.
2. *Disclosure* which means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

C. The health care components of the Division of Public Health Services (Agency) must make reasonable efforts to limit use and disclosure of individually identifiable health information to that which is *minimally necessary* to accomplish the intended purpose for the use or disclosure (including requests for information). The Agency should use the *reasonableness* principle to guide the development of criteria in meeting this requirement. The minimum necessary requirement applies to:

1. Uses or disclosures for payment or health care operations;
2. Uses or disclosures requiring the client to have an opportunity to agree or object;
3. Uses or disclosures that are permitted without the client's permission (except for those required by law or specified otherwise in the Agency's HIPAA Privacy Rule Policy Manual); and
4. Uses or disclosures by external Business Associates.

III. GUIDELINES:

A. Controlling the use of paper-based information that involves IIHI within the Agency presents special challenges in applying the minimum necessary requirements. The Agency relies more heavily on the development and implementation of policies and procedures, as well as self-policing. The Agency has developed the following controls on the use of IIHI:

1. The Agency has determined that all employees working in the Management Support section and program area staff as the employees who need access to IIHI and the categories of IIHI to which access is needed. (See "Confidentiality of IIHI" Policy.)
2. The Agency has developed and implemented procedures that limit routine disclosures of IIHI to the amount reasonably necessary to achieve the purpose of the disclosure.

B. The Agency receives written requests for IIHI from a client, an entity or person outside the Agency for disclosure to an entity or person outside of the Agency. The Agency may rely on a written request for disclosure as being the minimum necessary amount of IIHI if:

1. The disclosure is to a public official who represents that the request is for the minimum necessary information.
2. The request is from Rockingham County EMS.
3. The request is from a professional (Physician Extender, Program Coordinator, etc.) in the Agency's own workforce or from a Business Associate, and the professional represents that the request is for the minimum necessary information.

C. The Agency's Best Practices for the Minimum Necessary Requirement

1. The minimum necessary policy is intended to make the Agency evaluate current procedures and enhance protections needed to limit unnecessary or inappropriate access to, and disclosures of IIHI.
2. The Agency considers the best practice for sharing IIHI is to always limit such information to that which is necessary to accomplish the intended purposes of such use or disclosure.
3. The Agency will limit their requests for IIHI from other covered entities or individuals to that which is *reasonably* necessary to accomplish the intended purpose of such use or disclosure.
4. No use, disclosure, or request for a complete client record is considered minimally necessary unless specific justification is documented in the client's record.
5. Each request for use and disclosure of a client's IIHI that is non-routine **(**see page 4; [III][F][1.]**)** will be reviewed by the Privacy

Officer, and/or the Medical Records Supervisor to determine whether the request is *reasonably necessary* to accomplish the purpose of the use or disclosure.

D. Exceptions to the Minimum Necessary Requirement

The minimum necessary requirement *does not* apply to:

1. Disclosures to or requests by a health care provider for treatment *(treatment* is the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a client; or the referral of a client for health care from one health care provider to another*)*;
2. Uses or disclosures made to a client;
3. Uses or disclosures authorized by the client (or the client's personal representative);
4. Disclosures to the Secretary of the US Department of Health and Human Services (USHHS) for compliance enforcement;
5. Uses or disclosures required by law; or
6. Uses or disclosures required for compliance with the HIPAA Privacy Rule.

E. Uses of IIHI by Agency employees

1. The Agency shall categorize employees by their "need to know" profile and establish standards that reasonably limit inappropriate access to PHI.
2. For uses of IIHI within the Agency, each program area shall:

    a. Identify the persons or group of persons who need access to IIHI to carry out their job functions.
    b. Identify the type of PHI to which each person or group needs access, as well as the conditions under which they need the access.
    c. Make a reasonable effort to limit access of the workforce to only the information appropriate for their job function.

F. Standard Protocol for disclosures of IIHI by the Agency's workforce

1. For *routine, recurring disclosures* of IIHI by the Agency's workforce (examples: immunization records; postpartum home visit assessments; newborn home visit assessments; pre-employment,

employment and contracted drug screen testing, etc.) The Agency will:

a. Identify the types of IIHI to be disclosed.
b. Identify the types of persons who would receive the IIHI.
c. Identify the conditions that would apply to such access.

2. For *non-routine disclosures* of IIHI by the Agency's workforce, the Agency will:

a. Develop reasonable measures to limit IIHI to the minimum necessary to accomplish the purpose of the disclosure.
b. Use these measures to review non-routine disclosures on an individual basis to determine whether it is reasonably necessary to accomplish the purpose of the request.

G. Standard Protocol for making requests for IIHI by the Agency's workforce to persons or entities outside of the Agency:

1. For *routine, recurring* requests for IIHI (examples include local hospital emergency departments; immunization records; x-ray reports, etc.) by the Agency's workforce:

a. Describe what information is reasonably necessary for the purpose of the request; and
b. Limit the request for IIHI to that information.

2. *For all other* requests for IIHI by the Agency's workforce:

a. Ensure that each request is reviewed by the Medical Records Supervisor and/or the Agency's Privacy Officer to determine that the IIHI requested is limited to the information reasonably necessary to accomplish the purpose of the request.
b. One exception to the criteria allows access to the entire record to individuals involved in the *treatment* of the client.

3. Disclosure of the entire client record is prohibited without prior approval of the Agency's Privacy Officer. A criteria developed to control both requests for, and the disclosure of, the entire client record has been developed. Criteria justifies the reason the entire record is required.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PERSONAL REPRESENTATIVES POLICY

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 7/04; 6/22

I. POLICY:

The health care components of the Division of Public Health Services (Agency) are committed to the security of protected health information (PHI) contained in the medical records of the clients it serves. The Agency complies with all federal regulations under HIPAA and will recognize verified personal representatives acting on behalf of a client in making decisions relating to health care.

II. PURPOSE:

A. To establish guidelines for Agency staff to follow in confirming an individual as the verified personal representative of a client receiving care through the Agency.

B. Definitions:

1. IIHI - individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

   a. is created or received by a health care provider, health plan, employer, or healthcare clearinghouse;
   b. relates to the past, present or future physical, or mental health or condition of an individual; the provision of health care to an individual; of the past, present, or future payment for the provision of health care to an individual;
   c. that identifies that individual; and
   d. with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

2. PHI - protected health information means individually identifiable health information (IIHI) that is transmitted or maintained in any form or medium (includes electronic, paper or oral).

   Excludes IIHI in education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; records described at U.S.C. 1232g(a)(4)(B)(iv); and employment records held by a covered entity in its role as an employer.

3. Privacy Rule - means the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

III. GUIDELINES:

A. A personal representative is a person with legal authority to act on behalf of a client in making decisions related to health care. Some examples of personal representatives include:

1. Clients who have executed a document called a *health care power of attorney* [G.S.32A-15 et seq.] This document names a person who is authorized to make health care decisions for the client if the client becomes incapacitated. A client with a health care power of attorney (also called a "health care agent" or "health care attorney-in-fact") is a personal representative for purposes of the privacy rule.

2. North Carolina law provides for the appointment of guardians for individuals who have been determined by a court to be incompetent. A guardianship order often will give the guardian legal authority to consent to most medical care for the individual G.S. 35A-1241(a)(3). A guardian with authority to make health care decisions is a personal representative for purposes of the privacy rule.

3. Ordinarily, parents have legal authority to make health care decisions regarding their minor children [G.S. 7B-3400]. Therefore, in most circumstances, a parent is a personal representative of a minor child. See exceptions noted in section III (D) & (G) of this policy.

B. The Agency requires that a copy of the verified legal document appointing an individual as the personal representative for a client be placed in the client's medical record scanned and filed under consents tab in widgets.

Questions regarding the validity of a legal document that appoints an individual as the personal representative of a client shall be brought to the attention of the Medical Records Supervisor, the Privacy Officer, and/or the Assistant County Attorney for clarification.

C. Adults and Emancipated Minors § 164.502(g)(2)

General Rule: The Agency must treat a personal representative as if that individual were the client, for purposes of the rights and requirements of the privacy rule.

D. Exceptions to the General rule regarding emancipated minors and adults:

1. Emancipated Minors: In North Carolina, there are only two ways for a minor to be emancipated (see G.S. 7B-3500 et seq.):

   a. by marriage, or
   b. by an order of emancipation granted by a court.

2. Adults: In North Carolina, a person age 18 or older is an adult for purposes of making health care decisions.

D. Limitation: The rule states that a person is treated as a personal representative only with respect to PHI that is relevant to the personal representation. Look at the document that establishes the individual as the personal representative to determine the scope of the personal representative's authority.

A health care power of attorney grants a health care agent the authority to "request, review, and receive any information, verbal or written, regarding [the individual's] physical and mental health ... and to consent to disclosure of this information." G.S. 32A-25. However, the law also states that the individual may limit or restrict the health care agent's authority G.S. 32A-19(c). The health care power of attorney document therefore defines the scope of the personal representation with respect to access to PHI.

F. Unemancipated minors § 164.502(g)(3)

General rule: When applicable law gives a parent, guardian, or person acting in loco parentis (ILP) the authority to make health care decisions on behalf of an unemancipated minor, the Agency must treat the parent, guardian, or person ILP as a personal representative for purposes of the privacy rule.

G. Exceptions to the General Rule regarding unemancipated minors:
Under the following circumstances, the parent, guardian, or person ILP may not be treated as a personal representative, and the minor must be treated as the individual for purposes of the privacy rule.

1. If the minor consents to the health care service and no other consent is *required* by law (regardless of whether such consent has actually been obtained), the parent, guardian, or person ILP may not be treated as the personal representative, unless the minor requests that they be treated as such.

2. If the minor may lawfully obtain care without the consent of a parent, guardian, or person ILP, and the minor, a court, or another person authorized by law consents to the service, the parent, guardian, person ILP may not be treated as the personal representative.

3. If the minor's parent, guardian, or person ILP assents to an agreement of confidentiality between a health care provider and the minor regarding a health care service, the minor's parent, guardian, or person ILP may not be treated as the minor's personal representative with respect to PHI pertaining to that service.

H. Notwithstanding the above General rule and exceptions, the Agency should look to state laws to determine whether and when to disclose an unemancipated minor's PHI to parent, guardian, or person ILP:

1. The Agency may disclose an unemancipated minor's PHI to a parent, guardian or person ILP if an applicable provision of state law permits or requires disclosure.

2. The Agency may not disclose an unemancipated minor's PHI to a parent, guardian, or person ILP if an applicable provision of state law prohibits it.

3. If there is no applicable law relating to a parent, guardian, or person ILP's access to the unemancipated minor's PHI, the Agency may choose whether to provide or deny such access. The decision to provide or deny access must be made by a licensed health care professional in the exercise of professional judgment, and must be consistent with state or other applicable law.

I. NC Law as related to Personal Representatives of unemancipated minors

1. G.S. 90-21.5(a) authorizes a health care provider to accept an unemancipated minor's consent for preventative services, diagnosis, or treatment of the following conditions:

a. Sexually transmitted diseases and other reportable communicable diseases;
b. Pregnancy;
c. Abuse of controlled substances or alcohol; and
d. Emotional disturbance.

2. Provided the minor has the capacity to consent to this care, no other consent is required by law. G.S. 90-21.4(b) states that a health care provider shall *not* notify a parent, guardian, person ILP, or legal custodian with authority to consent to health care about medical services in G.S. 90-21.5 except in two circumstances:

a. If in the health care provider's opinion notification is essential to life or health of the minor, the health care provider *should* notify

the parent, guardian, person ILP, or legal custodian with authority to consent to health care; or

b. If the parent, guardian, person ILP, or legal custodian with authority to consent to care to health contacts the health care provider and inquires about the service, the health care provider *may* notify that person.

J. Deceased Individuals: § 164.502(g)(4)
(Also refer to Using and Disclosing PHI without Individual Permission Policy section. III .L.)

1. If applicable law gives an executor, administrator, or other person the authority to act on behalf of a deceased client or the client's estate, the Agency must treat the individual as a personal representative with respect to PHI related to the personal representation.

2. North Carolina Law as related to personal representatives of deceased clients:

G.S. 8-53 states that a deceased person's medical information may be disclosed upon the authorization of the person's executor or administrator, or if there is no executor or administrator, the next of kin. The Agency must treat a deceased client's executor or administrator - or in their absence, the client's next of kin - as a personal representative with respect to disclosures of PHI.

K. Exceptions for Abuse, Neglect, and Endangerment Situations § 164.502(g)(5)

1. The Agency may elect not to treat a person as a personal representative if both of the following circumstances (a) and (b) apply:

a. The Agency has a reasonable belief that either:

i. the individual has been or may be subjected to domestic violence, abuse, or neglect by the person who would be the personal representative, or
ii. treating the person as the personal representative could endanger the individual.

b. The Agency, in the exercise of professional judgment, decides that it is not in the best interest of the client to treat the person as the client's personal representative.
c. There is a related provision governing a personal representative's right to access PHI about the client in § 164.524(a)(3)(iii). The Agency may deny a personal representative's request for access if

"a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person." While the person would retain the personal representative status, access to PHI may be denied to the person under this provision. Refer to Agency policy, ACCOMMODATION OF CLIENT RIGHT TO ACCESS HIS/HER PROTECTED HEALTH INFORMATION.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: HIPAA VERIFICATION REQUIREMENTS POLICY

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The health care components of the Division of Public Health Services (Agency) are committed to the protection of protected health information (PHI) contained in the designated record sets of the clients it serves. The Agency complies with all federal regulations under HIPAA and will verify the identity of individuals and entities requesting PHI from the Agency prior to any disclosure permitted by HIPAA.

II. PURPOSE:

A. To establish guidelines for Agency staff to follow in verifying the identity and authority of individuals and covered entities requesting PHI from designated record sets maintained by the Agency

B. To prevent the disclosure of PHI to individuals who do not have the right to access the PHI.

C. To prevent the imposition of civil or criminal penalties on the Agency and the Agency's workforce for violation of federal regulations under HIPAA.

III. GUIDELINES:

A. Before making any disclosure permitted by the privacy rule, the Agency shall:

1. Verify the identity of the individual requesting PHI and the individual's authority to have access to PHI, if the identity and authority of the individual is not known to the Agency.

2. Obtain any documentation, statements, or representations that are required by this rule from the individual requesting the PHI.

3. Exception: The requirement that the identity of the individual requesting PHI be verified does not apply to disclosures made under § 164.510 (facility directories; disclosures to those involved in the client's care; disclosures for notification purposes; refer to *Using and Disclosing PHI without Individual Permission Policy*).

B. Identity of public officials

1. The Agency may rely, if such reliance is reasonable under the circumstances, on any of the following to verify identity when the disclosure of PHI is to a public official or individual acting on behalf of the public official:

   a. If the request is made in person, presentation of an agency identification badge, other official credentials, or other proof of government status.
   b. If the request is in writing, the request is on the appropriate government letterhead.
   c. If the disclosure is to an individual acting on behalf of a public official, wither of the following:
      i. a written statement on appropriate government letterhead that the person is acting under the government's authority, or
      ii. other evidence or documentation that establishes that the person is acting on behalf of the public official, such as a contract for services, memorandum of understanding, or purchase order.

2. Note that this provision says that a covered entity (Agency) *may* rely on the above methods of identification. It does not say a covered entity *must* rely on those methods, nor does it say that those are the *only* methods of verifying identity that are acceptable. It is probably most useful to view this as a "safe harbor" provision - meaning that, if one of the above methods is used to verify identity, the Agency may safely assume it is in compliance with the rule. Moreover, if the identification provided - the identification badge, the letter on letterhead, etc. - appears to be valid on its face, the Agency may rely on it without further inquiry into its validity. There may be instances in which it is reasonable for the Agency to rely on other means of verifying identity.

C. Authority of public officials

1. The Agency may rely, if such reliance is reasonable under the circumstances, on any of the following to verify a public official's authority to obtain PHI:
   a. A written statement of the legal authority under which the information is requested, or if a written statement would be impracticable, an oral statement of the legal authority.
   b. A request made pursuant to a warrant, subpoena, order, or other legal process issued by a grand jury or a judicial or

administrative tribunal is presumed to constitute legal authority

2. Note that this provision says a covered entity (Agency) *may* rely on the above methods for verifying a public health official's authority to obtain PHI. It does not say a covered entity *must* rely on those methods, nor does it say that those are the *only* methods of verifying authority that are acceptable. It is probably most useful to view this as a "safe harbor" provision - meaning that if one of the above methods is used to verify a public official's authority, the Agency may safely assume it is in compliance with the rule. There may be instances in which it is reasonable for the Agency to rely on other means of verifying legal authority.

D. Verification of conditions on disclosures: Reasonable reliance of facially adequate documents

1. The privacy rule requires particular documentation, statements, or representations from the individual requesting PHI before some disclosures can be made. When such items are required, the Agency may rely on documentation, statements, or representations that appear on their face to meet the applicable requirements. The Agency's reliance must be reasonable under the circumstances. (Refer to the *Use and Disclosure of PHI without Individual Permission Policy.*)

2. Special rules for specific types of disclosures:

   a. Disclosures governed by § 164.512(f)(1)(ii)(C) (disclosures in compliance with an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, or similar process authorized under law) have certain conditions attached to them. Refer to the *Using and Disclosing PHI without Individual Permission Policy.* Those conditions may be satisfied by the administrative subpoena or by a separate written statement that, on its face, demonstrates that the applicable requirements have been met.

   b. Disclosures subject to § 164.512(i)(2) (disclosures for research for which a wavier of individual authorization has been approved) have certain documentation requirements attached to them. Refer to the *Using and Disclosing PHI without Individual Permission Policy.* Those documentation requirements may be satisfied by one or more written statements, provided that each is appropriately dated and signed in accordance with the requirement of § 164.512(i)(2).

E. Exercise of Professional Judgment

1. The verification requirements are deemed to be met if the Agency relies on the exercise of professional judgment in making a use or disclosure in accordance with § 164.510 (facility directories, disclosure to those involved in the individual's care, disclosures for notification purposes).

2. The verification requirements are deemed to be met if the Agency acts on a good faith belief in making a disclosure in accordance with § 164.512(j) (disclosures to avert a serious threat to health or safety - refer to the *Using and Disclosing PHI without Individual Permission Policy*).

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: HIPAA COMPLAINT AND MITIGATION PROCEDURE POLICY

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 7/04; 6/24

I. POLICY:

The covered health care components of the Division of Public Health Services (Agency) comply with all federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and has developed procedures for investigating complaints, the mitigation of unauthorized uses and disclosures of PHI, and sanctions to be levied related to alleged violations of the privacy rule.

II. PURPOSE:

A. The Agency shall provide a means for individuals to make complaints concerning the Agency's HIPAA policies and procedures, as required by the privacy rule.

B. Unauthorized uses and disclosures of PHI shall be documented, investigated, mitigated, and sanctions levied, if indicated by the circumstances.

III. GUIDELINES:

A. The Agency shall document all complaints received and their disposition, if any.

1. Complaints are to be made in writing to the Privacy Officer.
2. If the Privacy Officer is unavailable, the complaint is to be made in writing to the Clinical Records Supervisor and then forwarded to the Privacy Officer.
3. The Privacy Officer will document all complaints received and send copies of all documentation related to the complaint as well as the disposition of the complaint to the Rockingham County Privacy Official within five business days of receipt of the complaint.
4. The Privacy Officer shall maintain a HIPAA Complaint log in their office. All complaint documentation received shall be maintained in written or electronic form for a period of six years from the date of the documentation of the complaint or from the date the documentation was last in effect, whichever is later.

B. The Agency shall have and apply appropriate sanctions against members of its workforce for failure to comply with the HIPAA privacy policies and procedures of the Agency.

1. Violations of the Agency HIPAA Confidentiality Policy or of any policy or guideline shall be dealt with pursuant to the *Rockingham County Personnel Policy Handbook* (**Policy 7**).

    a. Documented violations and sanctions levied may also be retained in the employee's personnel file
    b. The Agency shall document the sanctions that are applied, if any.

2. Sanctions may include, but are not limited to any of the following:

    a. Counseling by the Privacy Officer,
    b. Remediation of HIPAA Training,
    c. Disciplinary action, and
    d. Termination.

3. Sanctions applied will be documented in the HIPAA Complaint Log in the Privacy Officer's office.

4. Blatant, deliberate violation of the confidentiality policies of the Agency may result in immediate termination of the employee as well as the possible imposition of civil and/or criminal penalties.

C. The Agency shall mitigate, to the extent practicable, any harmful effects that are known to the Agency of a use or disclosure of protected health information (PHI) in violation of its policies and procedures or the requirements of the privacy rule by the workforce of the Agency or its business associates.

1. Incidental disclosures occur even when precautions are taken, and procedures have been followed. PHI is disclosed inadvertently. The Privacy Rule recognizes that incidental disclosures may occur. The circumstances of the disclosure will determine if mitigation is required.

2. As soon as any workforce member of the Agency is made aware of a PHI use or disclosure violation of the Agency's HIPAA Policies, or in violation of a Business Associate Agreement, the workforce member shall immediately inform the Privacy Officer of the improper use or disclosure.

3. The Privacy Officer, upon receiving the information regarding the improper use or disclosure, shall determine whether there is a known harmful effect from the use or disclosure and if so, shall immediately take steps to mitigate, to the extent practicable, the harmful effects.

4. Mitigating steps include, but not limited to:

   a. Retrieving improperly released information,
   b. Destroying the improperly released information by the receiving party,
   c. Educating the receiving party regarding the confidentiality of the information, and/or
   d. Having the receiving party sign a confidentiality agreement not to use or disclose the information in any way or in any form.

5. The Privacy Officer receiving the information regarding the improper use or disclosure shall confirm that the improper use or disclosure of PHI is documented in the client's **EHR record** such that it would be included in any future accounting of uses or disclosures.

E. The Agency shall refrain from intimidating or retaliatory acts as required by the privacy rule (§ 164.530(g)).

F. The Agency shall refrain from requiring individuals to waive their rights, as required under § 160.306 or § 164.530(h) of the privacy rule.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION WITH AN AUTHORIZATION POLICY

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 7/04; 5/08; 6/24

I. POLICY:

The health care components of the Division of Public Health Services (Agency) comply with all federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Agency is required to obtain an individual's written authorization for use and disclosure of protected health information (PHI) unless the use or disclosure is required or otherwise permitted by the Privacy Rule, such as those allowed by law related to health oversight activities, judicial proceedings, law enforcement and for treatment, payment and health care operations.

II. PURPOSE:

To identify the steps to be taken when an authorization for the use or disclosure of individually identifiable health information (IIHI) or protected health information (PHI) is received from an external entity or individual.

III. GUIDELINES:

A. Upon receipt of a valid written authorization for disclosure or use (that has all of the required elements) of PHI from an entity or person who is not a member of the Agency's staff, and who is authorized to use such information for purposes of treatment, payment or health care operations, the request shall be forwarded to the Medical Records Supervisor. The required elements of a valid authorization include the following:

1. The name or other specific identification of the person(s), or classes of persons, authorized to make the requested use or disclosure.
2. The name or other specific identification of the person(s), or class of persons, to whom the Agency may make the requested use or disclosure.
3. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
4. A description of each purpose of the requested use or disclosure.
   - The statement "at the request of the individual" is sufficient description of purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of purpose.

5. An expiration date or event that *relates* to the individual or the purpose of the use or disclosure. (examples)

    a. Valid authorization: if a client was being treated for a specific condition, a valid expiration date would be 60 days after the last treatment for condition "X" or an authorization that expires after it is filled if the request is for a one time event (i.e., release of records to an employer).
    b. The statement "end of research study" or similar language is sufficient if the authorization is for a use or disclosure of PHI for research.
    c. The statement "none" or similar language is sufficient if the information is for the creation and maintenance of a research database or research repository.

6. Signature of the individual or personal representative (the person who is the subject of the PHI)

    - If the authorization is signed by a "personal representative" of the individual, a description of such representative's authority to act for the individual must also be provided. According to the preamble to the final rule (August 14, 2002), the rule requires that covered entities verify and document a person's authority to sign an authorization on an individual's behalf.

        * Personal representative: Generally, if under state law a person has the authority to act on behalf of an individual, the covered entity must treat such person as the "personal representative" of the individual. § 164.502(g). With some exceptions, the personal representative must be treated as the individual, i.e., allowed to exercise the rights of the individual.

7. Date that the authorization was signed by the individual or personal representative.

8. A statement that notifies the individual of the right to revoke the authorization in writing that includes either:

    a. The exception of the right to revoke and a description of how the individual may revoke the authorization, or
    b. To the extent that the information referred to in "a." Is included in the Notice of Privacy Practices, a reference to the covered entity's notice.

9. Either:

    a. A statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization (if such conditioning is prohibited by the privacy rule), or
    b. A statement about the consequences of refusing to sign the authorization (if conditioning is permitted by the privacy rule).

10. A statement about the potential for PHI disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and no longer protected by the privacy rule. This statement is necessary because the recipient may not be a covered entity and, therefore, may not be subject to the privacy rule. While a general statement to this effect will suffice, a covered entity has the discretion to provide a more definitive statement where appropriate. For example, if a covered health care provider is requesting the authorization so that it may receive PHI for its own use from another health care provider, the covered health care provider may provide assurances that the information will remain subject to the privacy rule.

B. An authorization shall not be considered valid if the document submitted has any of the following defects:

1. The expiration date has passed or the expiration event is known by the Agency to have occurred;
2. The authorization has not been filled out completely, with respect to elements described in section III. A. (1 through 10) of this policy;
3. The authorization is known by the Agency to have been revoked;
4. The authorization violates section III. C or D of this policy, if applicable.
5. Any material information in the authorization is known by the Agency to be false.

C. Compound Authorizations: An authorization for use or disclosure of PHI may *not* be combined with any other document to create a compound authorization except as set forth in III. C. 2. of this policy, below.

1. Example: An authorization for use and disclosure of PHI may not be combined with a consent to receive treatment or a consent to assign payment of benefits to a provider. It cannot be combined with any other legal permission from the individual.
2. Exceptions:

    a. An authorization for the use and disclosure of PHI for a specific research study may be combined with any other type

of written permission for the same research study, including a consent to participate in such research.

b. An authorization for the use or disclosure of psychotherapy notes may only be combined with another authorization for the use or disclosure of psychotherapy notes. For example: an authorization for the use or disclosure of psychotherapy notes for multiple purposes - treatment and research - may be combined in a single document, but may not be combined with authorizations for use and disclosure of other PHI.

c. An authorization for the use and disclosure of PHI may be combined with any other such authorization (other than an authorization for a use or disclosure of psychotherapy notes); and except when a covered entity has conditioned the provision of treatment, payment, and enrollment in the health plan, or eligibility for benefits on the provision of one of the authorizations.

   i. Example/multiple purposes: an authorization for the disclosure of the individual's demographic information for both marketing and fundraising purposes.
   ii. Example/multiple entities: a crisis center, an inpatient alcoholism treatment program, and a provider of supportive housing for persons with disabilities may want to work together to coordinate treatment and housing services for homeless individuals who initially seek help from the crisis center. The three agencies could develop a single authorization form, to be signed by clients who agree to have them coordinate these services, which authorizes each agency to disclose to and receive from the others PHI about the client that is needed for the purpose of enabling them to provide and coordinate that client's treatment and housing services.

D. Documentation:

1. Authorization: The Agency must maintain the written authorization, or an electronic copy as documentation.
2. Revocation: The Agency must maintain the written revocation, or an electronic copy, as documentation.
3. Period of retention: Documentation must be retained for six years from the date of its creation or the date when it was last in effect, whichever is later. § 164.530(j)

E. The Medical Records Supervisor shall determine whether the disclosure or use is authorized by law or as otherwise allowed and will verify that the authorization itself is valid.

If the Medical Records Supervisor is unable to determine whether the disclosure or use is authorized or permitted by law and Agency policy or to confirm the validity of the authorization, she will consult with the Privacy Officer and/or the Assistant County Attorney before taking action on it.

F. The Medical Records supervisor shall identify that portion of the designated record set that constitutes the minimum necessary to accommodate the request. Any use or disclosure must be consistent with the terms of the authorization.

G. To the extent routine disclosures are made pursuant to a client's authorization, the Medical Records Supervisor shall defer to the Agency's *Minimum Necessary Policy,* identifying that portion of the medical record that will be the minimum necessary on a routine basis to accommodate a routine request for disclosure or use.

H. The Medical Records Supervisor shall assure that appropriate entries are **made in the client's record**, regarding the disclosure or use.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: USING AND DISCLOSING PROTECTED HEALTH INFORMATION (PHI) WITHOUT INDIVIDUAL PERMISSION POLICY

DATE DEVELOPED: 3/31/03
REVIEWED: 7/04; 4/05; 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 7/04; 4/05

I. POLICY:

The health care components of the Division of Public Health Services (Agency) are committed to the protection of confidential health information contained in the designated record sets of the clients it serves. The Agency complies with all federal regulations under HIPAA, and will not disclose individually identifiable health information unless it is a situation covered under section § 164.512 of the privacy rule.

II. PURPOSE:

In some instances, protected health information (PHI) may be used or disclosed for purposes that have been determined to address important societal goals or needs. These "national priority" uses and disclosures may be made without the individual's permission. This policy addresses the sections of § 164.512 of the privacy rule (HIPAA) that apply to our Agency.

III. GUIDELINES:

A. Definitions used in this policy include the following:

1. Use - means the sharing, employment, application, utilization**,** examination, or analysis of individually identified health information within an entity that maintains such information.
2. Disclosure - means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

B. Verification Requirements:

1. § 164.514(h) of the privacy rule requires the Agency to:

   a. Verify the identity and authority of individuals seeking disclosure of PHI, and
   b. obtain any documentation, statements, or representations that the specific subsection of the rule governing the disclosure requires.

2. The verification requirements of § 164.514(h) apply to all the national priority uses and disclosures.

3. § 164.514(h) includes detailed requirements for how identity is to be verified and how conditions on disclosures are to be satisfied.

C. Minimum necessary:

1. The minimum necessary standard applies to all disclosures made under § 164.512, except for disclosures that are required by law.

2. Refer to the *Minimum Necessary Policy*.

D. Documentation:

1. The uses and disclosures authorized by this section must be documented in the individual's designated record set. Most of the disclosures must be included in the accounting of disclosures individuals may obtain from the Agency, pursuant to § 164.528. Refer to the *Client Right to an Accounting of Disclosures of Protected Health Information Policy*.

2. The privacy rule requires that the Agency inform the individual of some of the uses and disclosures authorized in § 164.512. When the requirement exists, the individual may be informed orally. The fact that the information was given should be documented in the client's designated record set.

3. In some circumstances, the Agency may ask the individual to agree to the use or disclosure. The individual's agreement can be oral. The fact that the individual agreed should be documented in the client's designated record set.

E. Uses and disclosures under § 164.512 are permitted but not required by the privacy rule.

1. This means that, in most instances, the Agency may not choose whether to make the use or disclosure without the individual's permission.

2. However, some of the disclosures that are only *permitted* by § 164.512 are *required* by state law in North Carolina. The Agency may not choose whether or not to make disclosures that are required by state law, the Agency *must* make those disclosures.

3. Some of the disclosures that are permitted by the privacy rule are *not* permitted under state law in North Carolina. The Agency should determine its obligations under state law before making a disclosure that is permitted by § 164.512.

F. Disclosures required by law: § 164.512(a)

1. Permitted disclosure: The Agency may use or disclose PHI to the extent that such use or disclosure is required by law.

   a. Definition: "Required by law" means a mandate contained in law that compels a covered entity to make a use or disclosure of PHI and that is enforceable in a court of law. The term includes but is not limited to:
      i. court orders;
      ii. court ordered warrants;
      iii. subpoenas;
      iv. summons issued by a court, grand jury, a government or tribal inspector general;
      v. an administrative body authorized to require the production of information;
      vi. a civil or an authorized investigative demand;
      vii. Medicare conditions of participation with respect to health care providers participating in the program;
      viii. statutes and regulations that require the production of information, including statutes and regulations that require such information if payment is sought under a government program providing public benefits.
   b. Examples from North Carolina law:
      i. G.S. 130A-209(a) requires all health care facilities that detect, diagnose, or treat cancer to report diagnoses of cancer to the central cancer registry. The privacy rule permits this disclosure because it is required by a state statute.
      ii. G. S. 130A-143(6) states that information identifying a person with a communicable disease (such as HIV) may be released pursuant to a court order. The privacy rule permits this because a disclosure pursuant to a court order is a disclosure required by law.

2. Special procedures: There are specific procedures in the rule that must be followed when a "required by law" disclosure pertains to any of the following:

   a. Disclosures about victims of abuse, neglect, or domestic violence that are required by law must be made according to the procedures set forth in § 164.512(c) [see III (H) of this policy].
      i. exception: this does not apply to reports of child abuse or neglect, which are covered by § 164.512(b) (public health activities).

b. Disclosures for judicial or administrative proceedings that are required by law must be made according to the procedures set forth in § 164.512(e) [refer to III (J) of this policy].
c. Disclosures for law enforcement purposes that are required by law must be made according to the procedures set forth in § 164.512(f) [refer to III (K) of this policy].

G. Public health activities: § 164.512(b).

1. Permitted disclosure: The Agency may disclose PHI to a public health authority that is authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury or disability, including but not limited to the reporting of disease, injury, vital events (such as birth or death), and the conduct of public health surveillance, public health investigations, and public health interventions.

a. Definition: The privacy rule defines a "public health authority" as an agency, individual, or other entity that meets both the following conditions:
i. it is an agency or authority of the United States, a State, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from such an agency, including the agency's employees, agents, contractors, and other persons or entities to whom the agency has granted authority, and
ii. it is responsible for public health matters as part of its official mandate.

Note: In North Carolina, we use the term "public health authority" to refer to one specific type of local public health department. The privacy rule's use of the term is considerably broader.

b. Examples from North Carolina law:
i. G.S. 130A-135 requires physicians to report known or suspected cases of certain communicable diseases to the local health department. A local health department meets the privacy rule's definition of "public health authority". The privacy rule therefore permits this disclosure without individual permission.
ii. G.S. 130A-5(2) authorizes the NC Secretary of Health and Human Services to "investigate the causes of epidemics and of infectious, communicable and other diseases affecting the public health in order to control and prevent these diseases." In exercising this authority, the Secretary may "obtain ... A copy or a summary of pertinent portions

of privileged medical records deemed necessary for investigation of a disease or health hazard that may present a clear danger to the public health." The Secretary meets the privacy rule's definition of "public health authority" and therefore the disclosure is permitted without the individual's permission.

c. Permitted disclosure: The Agency may also disclose PHI to an official of a foreign government agency that is acting in collaboration with a public health authority.

d. Permitted use: An agency that is also a public health authority may use PHI in all cases in which it would be permitted to disclose PHI for the public health activities listed above.

2. Permitted disclosure: The Agency may disclose PHI to a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.

North Carolina law: G.S. 7B-301 *requires* any person who has cause to suspect that a child is abused, neglected, or dependent or that a child has died as a result of maltreatment, to make a report to the county department of social services (DSS). Therefore, the privacy rule permits this disclosure.

3. Permitted disclosure: The Agency may disclose PHI to a person subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety, or effectiveness of the FDA-regulated product or activity. The purpose for which disclosures may be made include:

a. To collect, report adverse events, product defects or problems, or biological product deviations.
b. To track FDA-regulated products
c. To enable product recalls, repairs, replacements, or "lookback" (including locating and notifying individuals who have received products that have been recalled, withdrawn, or are the subject of lookback)
d. To conduct post-marketing surveillance.

4. Permitted disclosure: The Agency may disclose PHI to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition if the Agency is authorized by law to notify such person as necessary in order to conduct a public health intervention or investigation.

a. North Carolina law: G.S. 130A-143 makes all information and records that identify a person with a "reportable" communicable disease strictly confidential and only allows the information to be released in designated circumstances. The statute allows the release of information when it is made in accordance with the state's communicable disease rules. In general, although the communicable disease rules allow individuals who have been exposed to a disease to be notified of the exposure, they do *not* permit the disclosure of the identity of the person to whom they were exposed. Thus, in general, the Agency is *not* authorized by law to tell potentially exposed persons the name of the person who exposed them.

i. Definition: There are more than 90 "reportable" communicable diseases in North Carolina. See 15A NCAC 19A.0101.

ii. Exception: There is a limited exception for a local health director to reveal the identity and diagnosis of an individual with a reportable communicable disease *other than HIV or an STD* to a limited group of people. This exception applies only to the local health director and should not be relied upon by any other covered entity.

iii. Exception: There are also limited exceptions that allow attending physicians or persons who have had a non-sexual exposure to blood or bodily fluids of another person (such as an accidental needlestick) to be notified of the other person's HIV**,** HCV and HBV status. See 15A NCAC 19A.0202(4) and 19A.0203(b)(3).

iv. Recommended practice: In general, the Agency should not disclose the name of a person with a communicable disease or condition to a person who has been exposed to that disease or condition.

5. Permitted disclosure: The Agency may disclose PHI to an employer about an individual who is a member of the employer's workforce if all of the following conditions are met:

a. The Agency is a covered health care provider who is either a member of the employer's workforce or is providing health care to the individual at the employer's request, and the disclosure is for one of the following purposes:

i. to conduct an evaluation relating to medical surveillance of the workplace, or

ii. to evaluate whether the individual has a work-related illness or injury.

b. The PHI that is disclosed consists of findings concerning a work-related illness or injury or workplace-related medical surveillance.

c. The employer needs such findings to comply with its obligations under the federal Occupational Safety & Health Act (OSHA), the federal Mine Safety & Health Act, or a similar state law, to record the illness or injury, or to carry out responsibilities for workplace medical surveillance. For example, federal OSHA regulations require employers to record work-related injuries and illness if medical treatment is necessary.

d. The covered health care provider provides written notice to the individual that PHI relating to medical surveillance of the workplace and work-related illnesses and injuries is disclosed to the employer. There are two ways the notice may be given:

i. by giving a copy of the notice to the individual at the time the health care is provided, or

ii. if the health care is provided on the employer's work site, by posting the notice in a prominent place at the location where the health care is provided.

Note: This notice is separate from the notice required by § 164.520.

6. Permitted disclosure: The Centers for Disease Control and Prevention, Lead Poisoning Prevention Branch (CDC) and the U.S. Environmental Protection Agency, Office of Enforcement and Compliance Assurance and Regions 1 – 10 (collectively, EPA) in response to requests for clarification regarding the confidentiality of childhood lead poisoning data states that the EPA, for purposes of this program, functions as a public health authority as defined by 45 CFR 164.501. Therefore, information that is reasonably limited to that which is minimally necessary to accomplish a compelling public health need as related to lead poisoning investigations may be disclosed to the EPA, without authorization, including the addresses of housing units involved (45 CFR 164.512(b)).

H. Abuse, neglect, and domestic violence: § 164.512(c)

1. Permitted disclosure: The Agency may disclose information about an individual believed to be a victim of abuse, neglect, or domestic violence to a government authority authorized by law to receive reports of abuse, neglect or domestic violence.

a. Limitation: this section does not apply to reports of child abuse or neglect, which are covered by § 164.512(b) [see section III.(G)(2) of this policy].

b. Example of North Carolina law: G.S. 108A-102 requires any person having reasonable cause to believe that a disabled adult is

in need of protective services to make a report to the county department of social services (DSS). Protective services are defined as services "which are necessary to protect the disabled adult from abuse, neglect, or exploitation." G.S. 108A-101(n). Thus, the county DSS is the government authority that is authorized by law to receive reports of the abuse or neglect of a disabled adult in North Carolina, and the privacy rule permits this disclosure.

Note: The privacy rule *permits* the disclosure but state law *requires* it. In order to comply with state law, the Agency must make a report to DSS whenever there is reasonable cause to believe that a disabled adult is in need of protective services.

2. Special conditions/procedures:

   a. Disclosures of PHI made under this subsection must conform with one of the following circumstances:
      i. PHI may be disclosed to the extent that the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of the law.
      ii. PHI may be disclosed if the individual agrees to the disclosure.
      iii. PHI may be disclosed to the extent that the disclosure is expressly authorized by statute or regulation AND one of the following applies:
         - the Agency, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims, or
         - if the individual is unable to agree to a disclosure because of incapacity, a law enforcement or other public health official authorized to receive the report represents that the PHI to be disclosed is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.
   b. The Agency upon making a disclosure under this section must promptly inform the individual who is the subject of the PHI that the disclosure has been or will be made, except in the following circumstances:
      i. the Agency need not inform the individual if the Agency, in the exercise of professional judgment, believes that

informing the individual would place the individual at risk of serious harm; or

ii. the Agency need not inform a personal representative about the disclosure if the Agency, in the exercise of professional judgment, reasonably believes the personal representative is responsible for the abuse, neglect, or other injury and that informing the representative would not be in the best interests of the individual.

I. Health oversight activities: § 164.512(d).

1. Permitted disclosure: The Agency may disclose PHI to a health oversight agency for oversight activities that are authorized by law. The types of oversight activities for which disclosures may be made include audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of the health care system, government benefit programs for which health information is relevant to beneficiary eligibility, entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or entities subject to civil rights laws for which health information is necessary for determining compliance.

a. Exception: Disclosures may *not* be made for purposes of an investigation or other activity which:

i. the individual is the subject of the investigation or activity, and

ii. the investigation/activity does not arise out of and is not directly related to one of the following:

- the receipt of health care
- a claim for public benefits related to health, or
- qualifications for, or receipt of, public benefits or services when a client's health is integral to the claim for the benefits or services.

b. Exception to the exception: If a health oversight activity or investigation is conducted with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity/investigation is considered a health oversight activity for purposes of this section and the disclosure *may* be made.

c. Examples from North Carolina law:

i. G.S. 122C-25 authorizes the NC Secretary of Health and Human Services to review patient records as part of an inspection of a mental health facility. Health oversight activities include inspections, when authorized by law.

Therefore, the privacy rule permits this disclosure of PHI.

ii. G.S. 131E-80 authorizes NC HHS to review any hospital record pertaining to the admission, discharge, medication, treatment, medical condition, or history of past or present clients, for the purpose of determining compliance with the Hospital Licensure Act. Health oversight activities include inspections and other activities necessary for the oversight of the health care system, when authorized by law. Therefore, the privacy rule permits this disclosure of PHI.

2. Permitted use: If the Agency is also a health oversight agency, the Agency may use PHI for its health oversight activities.

J. Judicial and administrative proceedings: § 164.512(e).

1. Permitted disclosure: The Agency may disclose PHI in response to an order of a court or administrative tribunal, provided that the Agency discloses only the PHI expressly authorized by the order.

2. Permitted disclosure: The privacy rule permits the Agency to disclose PHI in response to a subpoena, discovery request, or other lawful process, without a court order, *if* one of the circumstances in a. or b. below applies:

a. The Agency receives satisfactory assurance from the party seeking the PHI that reasonable efforts have been made to ensure that the individual who is the subject of the PHI has been given notice of the request for the PHI.

i. the rule contains detailed criteria for determining when the party has provided "satisfactory assurance." Agencies that choose not to follow the recommended practice in III.(J.)(2)(c.)(ii), below, should consult § 164.512(e)(1)(iii) before concluding that satisfactory assurance has been provided.

ii. as an alternative to receiving satisfactory assurance from the party requesting the PHI, the Agency may itself give written notice to the individual that meets the rule's requirements.

b. The Agency receives satisfactory assurance from the party seeking the PHI that reasonable efforts have been made to secure qualified protective order.

i. The rule contains detailed criteria for determining when the party has provided "satisfactory assurance" and what constitutes a "qualified protective order." Agencies that

choose not to follow the recommended practice in III.(J)(2)(c)(ii) below, should consult §§ 164.512(e)(1)(iv) and 164.512(e)(1)(v) before concluding that satisfactory assurance has been provided.

ii. as an alternative to receiving satisfactory assurance from the party requesting the PHI, the Agency may itself seek a qualified protective order that meets the rule's requirements.

c. Information that is privileged under North Carolina should not be disclosed in accordance with the procedures described in a. and b. above.

i. G.S. 8-53 establishes an evidentiary privilege for communications between physicians and patients. Information that is subject to a privilege may not be disclosed in court proceedings without either (1) the patient's permission, or (2) an order of a court or the administrative tribunal compelling disclosure. Other state statutes establish privileges for communications between individuals and their psychologists, marital-family therapists, counselors, and others. See G.S. 8-53.2 through 8-53.12.

ii. Recommended practice: Do not disclose PHI that is subject to an evidentiary privilege in response to a subpoena, discovery request, or other lawful process without either the individual's authorization or a court order.

K. Law enforcement purposes: the Agency may disclose PHI for law enforcement purposes to law enforcement officials in limited circumstances. § 164.512(f).

1. Definition: "Law enforcement official" means an officer or employee of any agency or authority of the United States, a state or political subdivision of a state, a territory or political subdivision of a territory, or an Indian tribe, who is empowered by law to (1) investigate or conduct an official inquiry into a potential violation of law, or (2) prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

2. Permitted disclosures: The Agency may disclose PHI to a law enforcement official in the following circumstances:

a. When requested by law, including laws that require the reporting of certain types of wounds or other physical injuries, but not including laws pertaining to the reporting of child abuse or neglect or other victims of abuse, neglect or domestic violence**.**

Example from North Carolina law: G.S. 90-21.20 requires physicians and administrators of medical facilities to report gunshot wounds and other injuries and illnesses that may have been caused by criminal acts of violence to local law enforcement officials. The privacy rule permits this disclosure.

Note: the privacy rule *permits* the disclosure but state law *requires* it. In order to comply with state law, agencies *must* make a report to local law enforcement when they treat a patient for one of the illnesses or injuries that is named in the statute.

b. The privacy rule permits the Agency to disclose PHI in compliance with certain types of orders, listed below in i. through iii. The PHI that is disclosed must be limited to the requirement of the order.
   i. PHI may be disclosed in compliance with a court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer.
   ii. PHI may be disclosed in compliance with a grand jury subpoena.
   iii. PHI may be disclosed in compliance with an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that all of the following conditions are met:
      - the information sought is relevant and material to a legitimate law enforcement inquiry.
      - the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
      - De-identified information could not reasonably be used.

   These conditions may be satisfied by the administrative subpoena or a separate written statement that, on its face, demonstrates that the applicable requirements have been met. § 164.514(h)(2)(i)(A).

c. Information that is privileged under North Carolina should not be disclosed in accordance with the procedures described in a. and b. above. Information that is subject to a privilege may not be disclosed in court proceedings without either (1) the client's permission, or (2) and order of a court or the administrative tribunal compelling disclosure. See III (J)(2)(c)(ii) for recommended practices.

3. Permitted disclosure: The Agency may disclose a limited amount of PHI in response to a law enforcement official's request for the information, if the purpose of the request is to identify or locate a suspect, fugitive, material witness, or missing person. The Agency, in disclosing PHI under this subsection, must comply with all the following:

a. The Agency may disclose only the following information about the individual:
   i. name and address
   ii. date and place of birth
   iii. social security number
   iv. ABO blood type and rh factor
   v. type of injury
   vi. date and time of treatment
   vii. date and time of death, if applicable
   viii. a description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or mustache), scars, and tattoos.

b. The Agency may not disclose any PHI related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue (except for the limited information related to blood type listed above).

c. Note that disclosures for this purpose must be made in response to a law enforcement official's request. The Agency may not disclose the information unless a law enforcement official has asked for it.

4. Permitted disclosure: The Agency may disclose PHI about an individual who is or is suspected to be a victim of a crime *if* a law enforcement official requests the information and either:

   a. The individual agrees to the disclosure, or

   b. If the Agency is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, the Agency may disclose the PHI if all of the following conditions are met:
      i. the law enforcement official represents that the information is needed to determine whether a violation of law (by a person other than the victim) has occurred, and the information is not intended to be used against the victim;
      ii. the law enforcement official represents that immediate law enforcement activity that depends upon disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and
      iii. the Agency, in the exercise of professional judgment, determines that the disclosure is in the best interests of the individual.

   c. This subsection does not apply to disclosures that are governed by § 164.512(b) (relating to reports of child abuse and neglect) or § 164.512(c) (relating to reports regarding other victims of abuse, neglect, or domestic violence).

5. Permitted disclosure: The Agency may disclose PHI about a decedent to a law enforcement official for the purpose of alerting law enforcement of a death, if the Agency suspects that the death may have resulted from criminal conduct.

6. Permitted disclosure: The Agency may disclose PHI to a law enforcement official if the Agency believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Agency's premises.

7. Permitted disclosure: Agency staff providing care in response to a medical emergency, other than an emergency on the Agency's own premises, may disclose PHI to a law enforcement official if the disclosure appears necessary to alert law enforcement to the commission and nature of a crime; the location of the crime or of its victims; and the identity, description, and location of the perpetrator.

L. Decedents: § 184.512(g)

1. Permitted disclosure: The Agency may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

   a. Permitted use: The Agency that also performs the duties of a coroner or medical examiner may use PHI for these purposes as well.
   b. North Carolina law: G.S. 130A-383(a) requires attending physicians, hospitals, employees, emergency medical technicians, and others to report deaths that were unexpected, unattended, caused by suicide or homicide, or otherwise suspicious, unusual, or unnatural to the county medical examiner. The privacy rule permits this disclosure.

      Note: The privacy rule simply *permits* the disclosure but state law *requires* it. In order to comply with state law, the Agency *must* make a report to the county medical examiner when they know of a death that is required to be reported.

2. Permitted disclosure: The Agency may disclose PHI to funeral directors, consistent with applicable law prior to an individual's death if it is necessary for funeral directors to carry out their duties and the individual's death is reasonably anticipated.

M. Serious threat to health or safety: § 164.512(j)

1. Permitted disclosure: The Agency may disclose PHI if all of the following conditions are satisfied:

    a. The Agency in good faith believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public,
    b. The disclosure is made to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat), and
    c. The disclosure is consistent with applicable law and standards of ethical conduct.

2. Permitted disclosure:

    a. The Agency may use or disclose PHI if:
        i. the Agency, in good faith believes the use or disclosure is necessary for law enforcement authorities to identify or apprehend an individual who has made a statement admitting participation in a violent crime that the Agency reasonably believes may have caused serious physical harm to the victim, and
        ii. the use or disclosure is consistent with applicable law and standards of ethical conduct.
    b. Exception: the use or disclosure may not be made if the Agency learns the information:
        i. in the course of treatment, counseling, or therapy to affect the propensity to commit the criminal conduct that is the basis for the disclosure, or
        ii. through a request by the individual to initiate or to be referred for such treatment, counseling or therapy.
    c. Limitation: The only information that may be disclosed is the statement the individual made any of the following identifying/locating information:
        i. name and address
        ii. date and place of birth
        iii. social security number
        iv. ABO blood type and rh factor
        v. type of injury
        vi. date and time of treatment
        vii date and time of death, if applicable
        viii. a description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or mustache), scars and tattoos.

3. Permitted disclosure: The Agency may use or disclose PHI if:
   a. The Agency in good faith believes the use or disclosure is necessary for law enforcement authorities to identify or apprehend an individual who has escaped from a correctional institution or from lawful custody.
   b. The use or disclosure is consistent with applicable law and standards of ethical conduct.

4. Good faith: All of the disclosures under this subsection require the Agency to have a "good faith belief." The privacy rule states that the Agency will be presumed to have acted in good faith if the belief is based upon the Agency's actual knowledge, or if the belief is in reliance on a credible representation by a person with apparent knowledge of authority.

N. Specialized government functions: § 164.512(k)

1. Military and veterans' activities:

   a. Permitted use and disclosure: the Agency may use and disclose the PHI of individuals who are Armed forces personnel for activities military command authorities have deemed to be necessary to assure the proper execution of the military mission.
      i. for this provision to apply, the appropriate military authority must have published a notice in the Federal Register containing the following information:
         - appropriate military command authorities
         - the purposes for which the PHI may be used or disclosed.
      ii. the Agency may use and disclose PHI of individuals who are foreign military personnel to their appropriate military authorities for these same purposes.

2. National security and intelligence activities

   Permitted disclosure: The Agency may disclose PHI to authorized federal officials for the conduct of lawful intelligence, counterintelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 401 et seq.).

3. Protective services for the President and others

   Permitted disclosure: The Agency may disclose PHI to authorized federal officials for the provision of protective services to the President and other persons under the protection of the Secret Service and related federal entities, or for the conduct of investigations into threats against the

President and others under the protection of the Secret Service and related federal entities.

4. Correctional institutions and other law enforcement custodial situations

   a. Permitted disclosures: The Agency may disclose PHI about an inmate or other person in lawful custody to a correctional institution or a law enforcement official with lawful custody of the individual, if the correctional institution or law enforcement official represents that the PHI is necessary for:
      i. the provision of health care to the individual
      ii. the health and safety of the individual or other inmates
      iii. the health and safety of the officers, employees, or others at the correctional institution
      iv. the health and safety of the individual and officers or other persons responsible for transporting inmates or for their transfer from one institution, facility, or setting to another
      v. law enforcement on the premises of the correctional institution
      vi. the administration and maintenance of the safety, security, and good order of the correctional institution
   b. Permitted uses: A health care provider that is a correctional institution may use PHI of individuals who are inmates for any purpose for which the PHI could be disclosed.
   c. Limitation: For the purposes of the above, an individual is no longer an inmate when released on parole, probation, supervised release, or when he or she is otherwise no longer in lawful custody.

5. Agencies that are government programs providing public benefits

   a. Permitted disclosure: a health plan that is a government program providing public benefits may disclose PHI relating to eligibility for enrollment in the health plan to another agency administering a government program providing public benefits *if* a statute or regulation expressly authorizes or requires:
      i. the sharing of eligibility or enrollment information among agencies, or
      ii. the maintenance of eligibility or enrollment information in a single or combined data system accessible to all the agencies.
   b. Permitted disclosure: An agency that is a government agency administering a government program providing public benefits may disclose PHI relating to the program to another agency that is also a government agency administering a government program providing public benefits, *if*:
      i. the programs serve the same or similar populations, and

ii. disclosure of PHI is necessary:
- to coordinate the covered functions of the programs, or
- to improve administration and management relating to the programs' covered functions.

O. Worker's compensation: § 164.512(I)

Permitted disclosure: The Agency may disclose PHI to the extent necessary to comply with workers' compensation laws or laws relating to other similar programs that are established by law and provide benefits for work-related injuries or illness without regard to fault.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ACCESS CONTROL AND VALIDATION PROCEDURES

DATE DEVELOPED: 2/05
REVIEWED: 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services (Agency) shall implement policies and procedures in compliance with the HIPAA Security Rule to limit physical access to its electronic information systems and the areas in which they are located and ensure that only properly verified authorized personnel are allowed access.

II. PURPOSE:

The HIPAA Security Rule effective date is April 20, 2005. Access Control and Validation Procedures are identified as addressable (§ 164.310(a)(iii) & § 164.312(d) and require that the Division of Public Health Services implement procedures to control and validate an individual's identity prior to access of software programs for testing and revision.

III. GUIDELINES:

A. Workforce members shall be identified by their county identification card, which shall be worn at all times while on county government property or in county buildings or individual must provide authentication to verify identity. Refer to the Agency HIPAA Verification Requirements Policy, developed in 3/03 and reviewed/revised annually.

B. Authorized workforce members shall accompany visitors, vendors, and other non-workforce individuals who must access areas of the Agency that have electronic information systems. Refer to the Agency's Confidentiality of Individually Identifiable Health Information Policy, developed in 9/04 and reviewed/revised annually.

C. All Agency staff shall ensure the security of electronic information systems by ensuring that doors to the clinic area, medical record areas and employee entrances are closed securely upon entering and exiting.

D. Access to software programs for testing and revision shall only be allowed by data processing staff or pursuant to a contract that has been approved through the standard contract control procedure.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ACCESS OF ELECTRONIC PROTECTED HEALTH INFORMATION (EPHI) FROM AGENCY WORKSTATION

DATE DEVELOPED: 2/05
REVIEWED: 2/06; 3/07; 5/08; 3/09; 3/10; 6/11; 6/12; 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 5/08; 6/24

I. POLICY:

The Division of Public Health Services (Agency) shall implement policies and procedures that specify the proper functions to be performed, the manner in which those functions are to be performed, and the physical attributes of the surroundings of specific workstations or class of workstations that can access electronic protected health information (EPHI).

II. PURPOSE:

The HIPAA Security Rule effective date is April 20, 2005. The workstation use standard (§ 164.310 (b) & (c)) requires that policies and procedures be implemented which specify the proper functions be performed, the manner in which those functions are performed, as well as the physical attributes of the surroundings of specific workstations and class of workstations that can control access to electronic protected health information (EPHI).

III. GUIDELINES:

A. Refer to Agency HIPAA Verification Requirements Policy, developed in 3/03 and reviewed/revised annually or as indicated. This policy sets forth guidelines for verification of identity and authority of individuals requesting disclosure of Protected Health Information (PHI) and EPHI.

B. Refer to Agency Confidentiality of Individually Identifiable Health Information Policy (HIPAA-8), developed in 9/94, and reviewed/revised annually or as indicated. This policy addresses Agency requirements related to maintaining the confidentiality of PHI and EPHI.

1. Item III (J)(14) of policy HIPAA-8 specifically relates to EPHI.
2. The Medical Records Room and all other offices that maintain computer workstations that can access EPHI are either:

    a. locked whenever the Agency is closed; or
    b. require a confidential password be used prior to accessing EPHI; or
    c. have screen protectors that are used on computers to protect EPHI.
    d. **Have a dual authentication requirement at each computer login session.**

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

IMMUNIZATIONS PROGRAM POLICIES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: IMMUNIZATIONS

DATE DEVELOPED: 12/06/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 3/15; 6/15; 6/16; 6/17; 6/18; 6/19; 6/21; 6/22; 6/23; 6/24

I. POLICY:

The Division of Public Health Services provides preventive health measures through the administration of vaccines to age appropriate populations within the county.

II. PURPOSE:

A. To provide age-appropriate immunizations to reduce the spread of vaccine preventable diseases.

B. To manage the outbreak of vaccine preventable diseases (see CD Policy).

III. GUIDELINES:

A. 1. The Division of Public Health Services will administer immunizations in accordance with General Statutes as updates and revisions are made. The agency will adhere to the "Standards for Pediatric Immunization Practice" as recommended by the National Vaccine Advisory Committee as well as recommendations from the Advisory Committee on Immunization Practices (ACIP), and according to the current year contract addendum.

2. The Division of Public Health Services will follow all conditions in the most recent Local Health Department Provider Vaccine Agreement checking VFC eligibility of the client for 100% of vaccines administered using state-supplied vaccine only for those clients eligible according to the most recent NCIP coverage criteria.

B. Only qualified personnel (APP, RN or LPN) will administer vaccines, who have been oriented to the current immunization schedule and who have been properly supervised during the orientation period. The clinical nurse supervisor will confirm each individual's competency in the administration of the vaccine and in the delivery of education to the client/parent/legal representative.

C. Maintain current standing orders, signed annually by a physician, which provide for appropriate immunizations and physician referrals when contraindications exist. The standing orders should contain temporary and permanent contraindications as outlined in the North Carolina Administrative Code. The standing orders must comply with the most current immunization schedule recommended by the ACIP and the NC Immunization Branch and must specify simultaneous administration of needed vaccines. Vaccines **needed** are reviewed at each routine visit.

D. Immunization Service Delivery:

1. To eliminate barriers that delay or prevent delivery of immunizations, and to assure the safe delivery of vaccines, the local health department agrees to stock all recommended and required vaccines as appropriate for the practice's population and provide them on time and simultaneously, as recommended and scheduled by the Advisory Committee on Immunization Practices (ACIP) and included in the UCVDP Coverage Criteria unless a valid contraindication exists.

2. Immunizations will be offered by appointment Monday through Friday from 8:00 a.m. to 4:30 p.m. Night clinics will be offered **by appointment most Thursdays from 5:00 p.m. to 7:00 p.m.** Immunizations will be made available without any prerequisites or reprisals. Immunizations are updated as needed and may require simultaneous administration during the visit.

   a. The current recommended childhood immunization schedule from the Advisory Committee on Immunization Practices (ACIP) is followed when administering the vaccines to ensure proper route, site, and needle length are used during administration in 100% of clients.
   b. Clients, parents, or guardians will be given the "Vaccine Information Statement" to review prior to vaccine administration. The staff will counsel, answer questions accordingly, identify any contraindications, and document in client's record or NCIR:
      - VIS given
      - Date of publication
      - Consent given for vaccines to be administered.
   c. A physician's order will be required if contraindications exist. The "Eligibility Criteria for NCIP Vaccine Usage" will be followed to verify any valid contraindications and to assess eligibility for simultaneous vaccines.
   d. All clients will have date of birth and demographic information verified prior to vaccine administration.

3. The Division of Public Health Services will maintain computer files on the Health Services Information System (HIS) on all immunization activities. Information is entered into the North Carolina Immunization Registry (NCIR) in an attempt to track the status of all children within Rockingham County with the major focuses centered on those children two and under. The Division of Public Health Services' encounter form is used to input immunization activities.

4. The Division of Public Health Services will assume accountability for all state supplied vaccines received.

   a. Transferred vaccine: Report (phone or fax) transferred vaccine to and from other UCVDP providers to the Immunization Branch. Information submitted will be vaccine type, lot #, manufacturer, exp date, and person that received the vaccine, along with date and time of transfer.

   b. Spoiled Vaccine: After consultation with the Immunization Branch return all spoiled vaccines (including partial vials and manufacturer pre-filled syringes) to the Immunization Branch with a <u>WASTED/EXPIRED VACCINE REPORT</u>. Do not send back syringes with needles, however account for those doses on the Wasted/Expired Vaccine Report.

      - Pre-drawn vaccine that is not used. Please note the Immunization Branch <u>strongly</u> discourages the practice of pre-drawing vaccine.
      - Handling and storage mishaps by provider staff
      - Vaccine that is left out of the refrigerator and becomes non-viable. Call the Immunization Branch first to help you determine the stability/viability of vaccine left out of the refrigerator/freezer.
      - Any temperature variance of vaccine from approved norms.
      - Refrigerator/freezer equipment problems where proof of repair or equipment replacement is not provided to the Immunization Branch within 30 days from the date you become aware of the situation.
      - Non-weather related power outages in which provider fails to take precautions.

   c. Expired Vaccine: Return all expired vaccines to the Immunization Branch with a WASTED/EXPIRED VACCINE REPORT.

E. Eligibility:

1. Immunizations will be offered regardless of county of residence. Immunizations that are state supplied will be offered at no cost to the eligible clients.

2. For compliance with the Federal VFC Program and state requirements:

   a. Screen all clients 0 through 18 years of age to determine the VFC eligibility and record eligibility in **the client's EHR record** each time a state-supplied dose is administered or retain copies of
   eligibility information for a period of three years following the date the vaccine was administered.
   b. State-supplied vaccine should not be administered to ineligible clients. Providers administering vaccine improperly may be subject to the **NCIP** Financial Restitution Policy. If state-supplied vaccine is inadvertently administered to a non-VFC eligible client the does(s) will be replaced per the NCIP Borrowing/Replacement Policy.

3. State law and the State Immunization Program requires privately purchased vaccines to be administered to those who do not qualify for VFC.

F. Staff:

The Division of Public Health Services ensures that staff is up to date on the most current immunization practices by providing ongoing educational updates on current ACIP immunization, recommendations, and by attending the state sponsored immunization and vaccine preventable disease control and surveillance workshops and conferences.

G. Duties of the Immunization Coordinator:

1. The immunization coordinator/immunization nurse on duty will be the person responsible for documenting temperatures on all vaccine refrigerators/freezers twice daily. The coordinator/ immunization nurse on duty is responsible for rotating stock during the day as needed.

2. The immunization coordinator will review the vaccine supply at least monthly to rotate expiring vaccine and tuberculin purified protein derivative (PPD).

3. The immunization coordinator/immunization nurse on duty will restock clinical immunization rooms and arrange stock to be consistent in each room.

4. The immunization coordinator will assure that immunization supplies are ordered to maintain a sufficient clinical supply. Supplies in storage will need to be rotated to prevent expiration of stored items.

5. The immunization coordinator/clinical supervisor will be responsible for overseeing off-site vaccination clinics. The coordinator will need to ensure proper handling, storage and transporting.

6. The immunization coordinator will receive all updates and revisions from the Immunization Branch recommendations and will be responsible for notifying immunization staff of these changes.

7. The immunization coordinator serves as the liaison for the Division of Public Health Services to community partners and private providers for immunization practices.

8. The immunization coordinator serves as the identity in staying up to date on changes with immunizations as related to ACIP, CDC, or Immunization Branch guidelines. This information is the disseminated among the Division of Public Health Services staff and the community.

9. The immunization coordinator ensures that immunization compliance, tracking, and documentation is complete and meets state guidelines.

H. Documentation:

1. Should the client/parent/legal representative refuse immunization or if there is some legitimate reason to postpone, the RN will counsel and advise to facilitate the administration of delinquent immunizations as quickly as possible and document within the client's NCIR record that vaccines were refused under "Client Comments".

2. If a parent/legal representative declines immunizations due to religious beliefs, the parent/legal representative must write the following statement on a plain piece of paper:

   "Due to religious conflict I do not wish for my child, *(spell out entire full name)*, born on *(child's DOB)*, to receive immunizations."

The parent/legal representative must sign and date the document and the nurse must witness, sign, and date. A copy must be made and the original document is filed in the client's chart. A stamped copy is given to the parent/legal representative. Add parent refusal of vaccines into NCIR under client comments.

3. The following information will be documented in the NCIR and electronic health record (EHR) by the end of the day:

   - The client's name and demographic information
   - The name, title, and address of the person who administered the vaccine
   - Allergies
   - Date of administration
   - Vaccine manufacturer
   - Vaccine lot number
   - Mode of administration
   - Site of administration
   - Date of relevant current VIS was given – date printed on the VIS

   A stamped copy of the NCIR record or EHR record will be given to the client/parent/legal representative.

4. The Division of Public Health Services will provide an immunization record, at no charge, to the parent, legal representative, or client each time an immunization is given as specified in G.S. 130A-154 and when needed for schools, child care facilities, colleges/universities, etc. The agency will keep immunization records permanently either electronically or in paper form.

5. In accordance with the signed Agreement for Immunization Provider Participation in the NCIR, completely and accurately document all historical information from a genuine certificate of immunization for all clients receiving any immunization from the LHD by the close of business each day. Accurately record VFC eligibility for all clients receiving immunization(s) in the NCIR each time a public or private immunization is administered.

6. Contingency plan for NCIR if internet service/power is interrupted is as follows:

   - If client has personal shot record, immunize client age appropriately according to current immunization practice.
   - Make a copy of record with newly added vaccine to be entered upon time of return of NCIR service.

- If a history is unobtainable, CDC recommends age appropriate vaccination.
- Document and enter into NCIR when service returns.

I. Monitoring/Follow-up/Tracking:

1. To assure quality of community-wide immunization service delivery, the local health department agrees to coordinate countywide immunization monitoring and follow-up, which at a minimum will include:

   a. Using the NCIR to identify LHD active clients and children residing in the county who are due or past due for immunizations.
   b. Assigning at least one staff person to conduct immunization monitoring and follow-up services to:
      - track 100% of active LHD clients that are due for immunizations
      - ensure that all immunizations administered and associated historical immunization information is entered into the NCIR
      - ensure that NCIR information/training is provided to interested private providers.
   c. Identifying and targeting under-immunized areas in the community using NCIR and conduct at least two interventions to improve immunization rate in one pocket of need area in the county by May 31st of every year.
   d. Integrating immunization screening and referral within WIC and other appropriate programs using NCIR and ensure a random selection of WIC clients' immunization rates are comparable to LHD annual assessment immunization rates.

2. Refer, as needed, clients being seen for immunization-only services to the following:
   - WIC Staff
   - **Care Management For At-Risk Children (CMARC)**
   - Health Check
   - Private Provider

J. Vaccine-Preventable Disease Surveillance - To ensure that vaccine-preventable diseases are identified, monitored, and managed, the local health department shall:

1. Upon the receipt of any suspect vaccine preventable disease or condition, investigate immediately the circumstances surrounding the occurrence of the disease or condition to determine the authenticity of the report;

2. Ensure that all health care providers are educated on reporting laws and requirements and are reporting any suspected vaccine-preventable disease to the local health department within 24 hours;

3. The local health department must notify the Communicable Disease Branch's on-call Epidemiologist within one hour by phone (919-733-3419) of any suspected cases of diphtheria, measles, polio, rubella, congenital rubella syndrome (CRS), mumps, and report by phone within 24 hours of any suspected cases of pertussis involving high-risk settings (such as healthcare settings and childcare settings providing care to infants);

4. Identify 100% of persons for whom control measures is required;

5. Follow the most current guidelines and recommendations for the prevention and treatment of vaccine-preventable disease, as outlined in the CDC's *Manual for the Surveillance of Vaccine-Preventable Diseases*, the American Public Health Association's *Control of Communicable Diseases Manual*, and the CDC's *Guidelines for the Control of Pertussis Outbreaks*;

6. Collect and submit appropriate laboratory examination specimens necessary to assist in the diagnosis of disease and indication of the duration of control measures required, including coordination with private physicians to submit appropriate specimens to the Division of Public Health's State Laboratory of Public Health;

7. Ensure two State laboratory Pertussis PCR and culture test kits with a non-expired media are available for immediate use in the local health department at all times;

8. Determine and ensure control measures have been provided for and complied with as directed in 10A NCAC 41A .0201;

9. Provide or ensure case management services following CDC guidelines to ensure:

    a. All pregnant women are tested for HBsAg during each pregnancy,
    b. All infants born to HBsAg-positive women and all infants born to women with unknown HBsAg status receive administration of the appropriate immunoprophylaxis and the first dose of hepatitis B vaccine within 12 hours of birth,
    c. All infants complete the hepatitis B vaccine series according to the most current ACIP recommended schedule, and
    d. All infants receive timely post-vaccination serology testing.

10. Follow the Agreement for Local Health Department Participation in the North Carolina Electronic Disease Surveillance System (NC EDSS) for reporting requirements.

11. Implement a comprehensive immunization policy for all local health department health care personnel who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air, as specified in the most current Immunization of Health Care Personnel: Recommendation of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC).

K. Storage/Handling/Transfer:

1. Make sure arriving vaccine shipments are never overlooked during busy periods. Open each shipment immediately and inspect contents. All vaccines purchased by the Health Department will be received by the accounting/purchasing clerk. **The purchasing clerk will notify the nurse who will obtain the vaccine and** check the vaccine for the name of the vaccine, lot #, the date received, number of doses, expiration date and the initials of the person receiving the vaccine. Invoices are kept in the Vaccine Inventory Book.

2. Open each shipment immediately and inspect contents. Note the condition of the vaccine and assure that the vaccines are at the appropriate temperature range per package thermometer strip.

3. Check your order against the invoice and the actual vaccines received. Check quantity, lot number and expiration dates of the vaccine. If there are any discrepancies, contact the Immunization Branch or manufacturer immediately.

4. For Varicella Vaccine, read and follow the instructions that accompany the shipment before handling. The Varicella Vaccine shipping container vaccine temperature check card must be WNL. If it is not, call Immunization Branch or manufacturer immediately.

5. If any vaccine seems warm or you have any questions about the condition of the vaccine at the time of delivery, mark the vaccine "DO NOT USE" and place it in the appropriate storage conditions apart from other vaccines. Call the Immunization Branch for consultation.

6. Depending on vaccine, refrigerate or freeze the vaccine immediately. If unsure about vaccine storage requirements, refer to the package insert or call the Immunization Branch.

7. Do not place unopened shipments of vaccine in the refrigerator/ freezer before examining the contents.

8. Vaccines taken from the Health Department for outside sites will be counted by two nurses in charge of the vaccine. The nurse will sign out on the log sheet for the number of doses received.

   On return to the building the vaccine will be counted and compared with the number of doses given at the outside site. All these transactions will be documented in the log book that includes name of vaccine, lot number, manufacturer, expiration date, number of doses and the names of nurses receiving vaccine. Any discrepancies should be reported to the Nursing Supervisor immediately.

9. a. The nurse who transports vaccines to the outside sites will be responsible for the safe return of all vaccines and responsible for ensuring that the number of doses given, plus the numbers of doses remaining, equal the number of doses of vaccine taken from the Health Department.

   b. The vaccine is transported in a cooler with conditioned frozen water bottles to ensure stability and to maintain temperature control. The MMR, MMRV, and Varicella must be kept frozen, in a separate container. Do not freeze other vaccines.

      (1) Vaccine must remain in the manufacturer's box during storage;

      (2) A digital data logger (DDL) with buffered probe must be stored with the vaccine in the cooler;

      (3) Vaccine boxes must not touch the ice pack at any time; separate with foam/bubble wrap;

      (4) Vaccine must be moved to refrigerated units at the end of the day;

      (5) Temperature in the cooler must be checked every 2 hours and recorded on a log with time and initials of the responsible nurse;

      (6) Temperatures between 36º to 46ºF (2º to 8ºC) must be maintained at all times; and

      (7) If at any time the thermometer indicates temperatures outside of the 36º to 46ºF (2º to 8ºC) range the following steps must immediately be taken:

      - Move vaccine to a refrigeration unit, and
      - Notify the Immunization Branch of the temperature before continued use of the vaccine.

10. Ordering, storage, and handling of the vaccines at the Division of Public Health Services will be maintained according to guidelines

set forth by the "Universal Childhood Vaccine Distribution Program" and updated as revisions are made.

a. Ordering

- Order all vaccines every three months or when needed. Stock enough vaccine to maintain a three-month supply, if you have the storage capabilities.
- Inventory current stock before placing an order.
- Total all doses administered from the previous month for each vaccine type. Compare to last year's doses administered data for the future three months. Use the highest of the 4 monthly doses administered reports to determine a three-month vaccine supply.
- Request all vaccines needed in one order, including Varicella, MMR, and MMRV.
- Vaccine orders are reviewed and adjusted so providers receive no more than a three-month vaccine supply. The order adjustment is based on the most current doses administered, prior year vaccine usage, and current inventory.
- Alert other office staff that you have placed a vaccine order and the order will arrive within 10 days.
- Alert staff when a Varicella, MMR, or MMRV order is placed. Varicella, MMR, and MMRV is sent directly from the manufacturer and takes one to two weeks to arrive after your order is placed with the Immunization Branch.

b. Handling

- Never leave vaccine out of the refrigerator or freezer when not in use. Check and log the refrigerator and freezer temperature twice a day, once in the morning and once in the evening before leaving, to ensure temperature is constant and the doors are closed.
- Record minimum/maximum temperatures every morning to verify constant temperatures are maintained overnight, on weekends, and holidays**.**
- Retain refrigerator and freezer logs for a minimum of three years.
- If an accident, emergency, or other abnormal situation occurs, place vaccine in a properly cooled refrigerator/ freezer. Mark the vaccine "DO NOT USE" and call the Immunization Branch immediately to verify if the vaccine is still viable.

- Rotate vaccine each week to ensure the vaccine with the shortest expiration date is being used first. Whenever possible, use the vaccine in one multi-dose vial before opening another. Don't discard vaccines prematurely. Almost all multi-dose vials of vaccine have preservatives in them and can be used until the expiration date on the vial unless there is visible contamination. However, you must discard multi-dose vials of reconstituted vaccine (e.g., meningococcal, yellow fever) if they are not used within a defined period after reconstitution. Refer to the vaccine package inserts for additional information.
- Ensure staff are aware of protocol for accepting vaccine deliveries and ensuring vaccines are appropriately stored immediately after arrival. Designate a staff member and a backup to be responsible for these activities.
- Use vaccine, which is dated only with the month and year, until the <u>end</u> of the month stated on the vial.

c. Storage – Read and follow the package insert on storage of vaccines.

- The refrigerator and freezer units should have their own certified digital data logger (DDL).
- Safeguard your pharmacy refrigerator and install a plug guard or a safety lock plug.
- Because temperatures fluctuate during the day, temperatures in refrigerator and freezer should be checked at the beginning and end of the day and documented.
- Documenting out of range temperatures:
  - Notify supervisor whenever you get an out of range temperature.
  - Move vaccines to another location and then determine if they are still viable. Check the condition of the unit. All seals tight? Is there excessive lint or dust on the coils? After you have made the adjustment document the date, time, temperature, what the problem was, the corrective action you took, and the results of the action and person notified.
  - Notify the Immunization Branch of **<u>any</u>** out of range temperature as soon as possible.
  - Recheck temperature every two hours until it returns to normal times two consecutive readings. Vaccine may be returned after 7 days of normal temperatures are recorded and verified by the Immunization Branch.

- Call maintenance if temperature remains out of range.

- Remind staff to close doors tightly each time they open them. Check seals on the doors regularly.
- Keep Varicella, MMR, and MMRV frozen. Varicella must be kept at - 15°C (+5°F) or below. At all times Varicella, MMR, and MMRV must be stored in a freezer that has its own external door separate from refrigerator.
- Storing MMR and MMRV vaccine in freezer with your Varicella vaccine significantly increases that it will remain viable should you have a power outage or refrigerator malfunction.
- Keep all other vaccines in the refrigerator at 2° to 8°C (36° to 46°F). Optimum temperature of 5°C (40°F). DO NOT FREEZE.
- Store refrigerated vaccines on the middle shelf or so that air circulates with the thermometer**.** Never store vaccine in the door, vegetable bin, plastic container, bottom of refrigerator, or near the cold air outlet of the freezer. Store on the shelves in open, labeled containers so that air can circulate around the vaccines.
- Disaster Recovery Plan is posted in the Pharmacy. Update as staff changes occur.
- Do not store food or biological specimens in the refrigerator storing vaccine.
- The Room #30 refrigerator stores one box of each refrigerated vaccine for daily distribution. The Copy Room refrigerators store all surplus vaccine. The **Copy Room** freezer stores all frozen vaccine.

  Temperature is monitored two times per day in each unit. Each unit is also connected to the Security Central Alarm System which is monitored for temperature 24/7.

d. Returning Vaccine

- Never send viable vaccine back to UCVDP. Always call the Immunization Branch first.
- Return all open vials, unopened vials and manufacturer's pre-filled syringes of spoiled or expired vaccine to the Immunization Branch with a completed Wasted/Expired Vaccine Report that is found in the NCIR. Do not send back syringes with needles; however, account for these doses on the Wasted/Expired Vaccine Report. Record the incident in the NCIR.

- Call the Immunization Branch at least four months before the expiration date if you have vaccine that you will not use before it expires for locations to redistribute.
- The provider shall pay the cost of state-supplied vaccines that were wasted through the provider's failure to properly store, handle, or rotate the vaccine.

11. Transferred vaccine: Record all vaccine transfers in NCIR or report (phone or fax) transferred vaccine to and from other UCVDP providers to the Immunization Branch.

L. Outreach and Education:

The Division of Public Health Services employees strive to encourage and promote the well being of children by informing the community about the various immunizations required. This community outreach is accomplished through health fairs, presentations, school involvement, parenting classes, WIC program, CMARC, and through physicians' offices in Rockingham County. Immunization tracking is reviewed in all programs.

Education of our clients is accomplished within all of the agency programs to better enhance the life and well being of each individual. Health Promotion and the Health Educators are better able to conduct educational classes within the schools, health fairs, and community groups.

1. To ensure the private providers in the community are educated about the immunization registry, the local health department agrees to respond to private providers' request for NCIR information, training and guidance.
2. To help teach clients and parents the value of immunizations and to ensure awareness of required immunizations, the local health department agrees to:
    a. Conduct and document appropriate community-based outreach and education activities.
    b. Present and review appropriate and current Vaccine Information Statement(s) (VIS) with each parent/guardian, person standing in loco parentis, or adult presenting the child for immunizations each time a client presents for the administration of vaccine in their native language, if available.
    c. Incorporate immunization education in prenatal, parenting and other health education curriculum.

M. Funding Guidelines:

Federal Immunization program funds will be used solely for the purchase of approved immunization program activities and supplies (promotional items cannot be purchased with federal funds).

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMERGENCY VACCINE MANAGEMENT PLAN / DISASTER RECOVERY PLAN

DATE DEVELOPED:
REVIEWED: 11/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 11/15; 6/16; 6/17; 6/17; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24

I. POLICY:

The Division of Public Health Services maintains an up-to-date written Vaccine Disaster Recovery Plan.

II. PURPOSE:

To outline procedures for protecting vaccine inventories in the event of an emergency or power outage.

III. GUIDELINES:

A. It is imperative that our pharmaceuticals, vaccines, and laboratory cold storage be maintained at the proper temperature without interruption. Naturally, any power outage is of major concern to our Agency. A temperature alarm is wired to our Room #30 refrigerator, our copy room freezer and refrigerators and our pharmacy refrigerator and freezer to alert of any temperature deviation.

B. Designated Person – Immunization Coordinator (Back-up person – other immunization nurses and/or clinical nurse supervisor)

- Monitors the operation of the vaccine storage equipment and systems daily;
- Tracks inclement weather conditions. Sets up and maintains a monitoring/notification system during times of inclement weather or other conditions that would create a shut down in power. An alarm/notification system is activated to maintain proper refrigeration. Determine if your refrigerator is having a mechanical failure (no lights in the refrigerator, no fan noise, etc.) or if the building has lost electrical power. Check with building maintenance to ensure that the generator is operational and has been activated. For maintenance of the refrigerator, notify the County Maintenance Department**.**

C. Emergency Procedures for Protecting Vaccine Inventories

1. Back-up system

- An emergency generator will assure power in the event of a power outage.
- In the event a back-up generator malfunctions, contact the on-call maintenance at (336) 205-2657 to see if able to regain generator function. If not, preparations should be made to have coolers, frozen ice packs to temporarily and safely store the vaccine. This system can also be used for temporary vaccine transfer from on-site to off-site.
- The health department must provide transportation.
- UNC Health Rockingham is the backup storage facility. (See transporting vaccines)
- Emergency Phone Numbers

  - Duke Power 1-800-Power-On
  - Temperature Alarm Company
    (Security Central 1-800-286-5699) - need acct #7086;
    REC #A2230
    Service call (336) 616-0450
  - UNC Health Rockingham (336) 623-9711

- County vehicles or volunteer drivers will be utilized to transport vaccine (accompanied by staff member – knowledgeable about vaccine storage, handling, and transporting)
- Emergency generator – pager for maintenance
  (336) 205-2657
- National Weather Service
- Manufacturers

  - Merck Sharpe and Dohme – 1-800-672-6372
  - Aventis Pasteur – 1-800-Vaccine or
    www.vaccine.shop.com
  - Glaxo Smith Kline – 1-888-825-5249
  - Wyth – 1-800-666-7248
  - Sanofi Pasteur 1-800-822-2400

2. Entering Vaccine Storage Facility

   a. Summary of Instructions Following Power Outage

   For short period of power outage:

   - Do not open freezers and refrigerators until power is restored, unless transferring vaccine off-site.
   - Most refrigerated vaccines are relatively stable at room temperature for limited periods of time. The vaccines of most concern are MMR and Varicella, which are sensitive to elevated temperatures. MMR may retain potency at

room temperature, depending on the duration of exposure. With regard to Varicella, CDC will consult with Merck Vaccines to determine the best course of action.

- Monitor temperatures; don't discard vaccines; do not administer affected vaccines until you have discussed use of these vaccines with public health authorities.

b. For extended periods of power outage: Administration must be notified to obtain entrance into locked pharmacy area.

Emergency Contacts for RCDHHS during disaster or power-outage

Name of Employee	Title of employee	Work phone	Home phone
Jennifer Love, RN Primary	Clinical Supervisor	336-342-8189	(cell # 336-932-3673)
Susan Cox, RN 1st back up	Immunization Coordinator	336-342-8257	(cell # 336-514-2873) **(home # 336-388-5314)**
Susan Young, RN 2nd back up	Director of Nursing	336-342-8151	(cell # 336-951-7549)

NCIR Helpdesk

Telephone Number	Fax Number
1-877-873-6247	1-800-544-3058

State

	Contact Person	Telephone Number
NC Immunization Branch	**Brandon Rector**	**919-218-8932**
Regional Immunization Nurse Consultant	Nurse Office On Call Or Heather Goodson	919-707-5575 (on call) 336-656-9203 (fax) 336-656-1260 (office) 919-538- 0919 (cell)

c. Floor map to pharmacy

- Enter back personnel entrance.
- Enter corridor – walk approximately 5 feet and go through single door.
- Turn left – walk approximately 15 feet and then turn right. Walk 26 feet and go through single door.
- Walk straight approximately 50 feet and go through single door.
- Continue walking straight approximately **15 feet**.

- Turn left – **2 refrigerators and a freezer** are on the right in the copy room.

d. Floor map to Room #30

- Enter back personnel entrance.
- Enter corridor – walk approximately 5 feet and go through single door.
- Turn right – walk approximately 23 feet and turn left. Walk approximately 44 feet and Room #30 door is on the left.
- Primary vaccine coordinator or back-ups have keys to access Room #30 and vaccine inside the refrigerator.

e. Back up transportation – The Division of Public Health Services vehicles may be utilized for transportation or the Sheriff's Department may be utilized – 634-3030.

3. Please notify the following for issues listed below:

Need	Contact	Number
a. Equipment Problems	Rockingham County Maintenance on-call staff	Pager 336-205-2657
b. Packing containers Frozen water bottles	The Division of Health and Human Services maintains a sufficient supply of available containers and frozen water bottles. Containers are located on bookshelf in Room 11.	
c. Back-up Storage Facility	UNC Health Rockingham Pharmacy 336-623-9711 or 336-627-6198 (after-hour switchboard) Jane Younts Todd Collins (back-up)	

Back-Up Vaccine Storage Sites

Alternate Facility	Point of Contact	Work Phone
UNC Health Rockingham	Jane Younts Todd Collins (back-up)	(336) 627-6198 8 am – 5 pm *After Hours* Page switchboard at Hospital (336) 623-9711

4. The following vaccines will be packed as listed to ensure priority in emergency and while the power is still working.

a. Pack the refrigerated vaccines first with an adequate supply of conditioned water bottles.

b. Remove and pack the varicella, MMR, and MMRV vaccine using frozen water bottles immediately before it is to be transported.

c. Pack and transport all vaccine if possible. If not, determine the most expensive vaccines such as MMR, MMRV and varicella.

d. Follow vaccine packing procedures for transport to backup storage facility.
   - Have vaccine packing instructions readily available for staff unfamiliar with packing procedures.
   - Open refrigerated units only when absolutely necessary and only after you have made preparations for packing and moving the vaccine to alterative storage sites.
   - Use properly insulated containers.
   - Use a properly placed data logging temperature monitoring device in each container.
   - Record vaccine type(s), quantity, date, time, and originating facility on the container.
   - Document the storage container temperatures at the time the vaccine is removed for storage at the alternate site.

e. Move vaccine to backup storage according to prearranged plans.
   - Use larger county vehicles to enhance transportation of multiple vaccines.
   - UNC Health Rockingham directions – 87 toward Eden, right onto Harrington Hwy, left onto Hwy 14, go approximately 3-5 miles. UNC Health Rockingham is on the corner of Hwy 14 and Kings Hwy. It will take approximately 15 minutes. Pharmacy is located on the 3rd floor. Enter the front of hospital and continue straight down hall past reception desk. Take the elevator to the 3rd floor. Pharmacy is on the left.
   - Assist hospital staff, if possible, in storing vaccines properly according to guidelines. Varicella/MMR/ MMRV in freezer, refrigerated vaccines in refrigerator, adequate circulation, functioning temperature monitoring device, accurate records maintained for temperature checks.
   - Record vaccine type(s), quantity, date, time, and originating facility on the container.
   - Document the storage container temperatures at the time the vaccine is removed for storage at the alternate site.

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Rockingham County Division of Public Health
North Carolina Immunization Program (NCIP)
EMERGENGY VACCINE MANAGEMENT PLAN / DISASTER RECOVERY PLAN

Clinic Name	Rockingham County Division of Public Health
Address	371 NC 65, Suite 204 Wentworth, NC 27375

Role	Name	Job Title	Home Phone	Cell Phone
Primary	Jennifer Love	Clinical Supervisor	NA	336-932-3673
Back-up	Susan Cox	Immunization Coordinator	**336-388-5314**	336-514-2873
Lead Physician	Kevin Howard	Medical Director	NA	336-932-5102
Office Staff	Susan Young	Director Of Nursing	NA	336-951-7459

In an emergency, contact the following people in order listed:

Role	Name	Job Title	Home Phone	Cell Phone
Primary	Jennifer Love	Clinical Supervisor	NA	336-932-3673
Back-up	Susan Cox	Immunization Coordinator	**336-388-5314**	336-514-2873
Office Staff	Susan Young	Director Of Nursing	NA	336-951-7549

Useful Emergency Numbers:

Service	Contact	Work Phone	Emergency Phone	Email Address
Regional Immunization Nurse	Heather Goodson	336-656-1260 919-538-0919 (cell)	*On call* 919-707-5575	Heather.goodson@dhhs.nc.gov
Regional Immunization Consultant	**Brandon Rector**	**919-218-8932**	**919-218-8932**	**brandon.rector@dhhs.nc.gov**
Electric Power Company	Duke Energy		1-800-POWER-ON	
Building Maintenance/ Maintenance	On call		336-205-2657 (pager)	
Refrigerator/Freezer Repair	Chrismon Refrigerator Sales and Service	336-349-6449		
Refrigerator/Freezer Alarm Company	Security Central	(336) 616-0450	1-800-286-5699	Acct 7086 REC #A2230

Back-Up Location:

Alternate Facility	Address	Contact	Work phone	Emergency phone
UNC Health Rockingham	117 E. Kings Hwy Eden, NC 27288	Jane Younts Todd Collins (back-up)	(336) 627-6198 8 am – 5 pm	*After Hours* Page switchboard at Hospital (336) 623-9711

Emergency Supplies:

Item	**Location**	**Item**	**Location**
Doors	Outside Personnel entrance	Keys	All swipe badge entries until key in pharmacy desk; key for Room #30
Flashlight Batteries	Room #11 Bookcase	Locks	All swipe key passes(work when power out)
Circuit Breakers	Behind pharmacy on hallway in front of break room in the closet	Alarms	Copy room / pharmacy / Room #30
Light Switches	On wall directly in front of entryway and on left hand side of door in the pharmacy	Packing Materials	Under pharmacy sink

Instructions for Entering the Building and Floor Plans

Before an Emergency

- Identify an alternative storage facility with a generator where vaccine can be stored (i.e., hospital, health department, fire department, etc.). Obtain verbal or written consent to use the facility as a backup location and ensure the facility has appropriate storage capabilities per NCIP requirements.
- Ensure the availability of staff to pack and move vaccine, and the availability at backup location.
- Ensure a means of transport for the vaccine to the backup facility and review transportation guidelines.
- Fill the empty space in your refrigerator with water bottles and line the sides and bottom of the freezer with frozen water bottles.
- Whenever possible, suspend vaccination activities BEFORE the onset of emergency conditions to allow sufficient time to pack and transport vaccine.

During an Emergency

- Assess the situation. Keep all refrigerators and freezers closed and if possible, continue to monitor temperatures. If not, record the temperature as soon as possible after the power is restored and the duration of the outage and report this information to the NCIP.
- Determine the cause of the power failure and estimate the time it will take to restore power. If a time frame for the restoration of power cannot be determined, do not leave vaccine in a non-working unit.
- Notify key staff as listed on this Emergency Plan.
- If the outage is expected to be long term (greater than 2 hours), transport the vaccine to backup facility.

Emergency Transportation

- Conduct an inventory before beginning transport and keep all vaccine in original packaging.
- Package refrigerated vaccine in a well-insulated container in the following order:
  1) conditioned frozen water bottles at the bottom of the cooler
  2) 1 sheet of corrugated cardboard over water bottles
  3) 1 inch of bubble wrap or foam
  4) vaccine with digital data logger buffered probe
  5) 1 inch of bubble wrap
  6) another sheet of cardboard
  7) another layer of conditioned frozen water bottles at the top of the cooler.
- Package freezer vaccine in a well-insulated container in the following order:
  1) frozen water bottles at the bottom of the cooler
  2) vaccine with thermometer
  3) frozen water bottles over the vaccine. Diluent should be transported with the vaccine at the appropriate storage temperatures
  4) fill top of cooler with bubble wrap.
- Upon arrival to backup facility, document transportation time, temperatures in cooler, and temperatures at the facility.

After an Emergency

- Do not discard or administer any affected vaccine. Mark vaccine with "DO NOT USE" sign and call the NCIP for further instruction about the viability of the vaccine.
- Record the temperature in the unit as soon as possible after power is restored. Continue monitoring until units are in range.
- Record the duration of the outage and maximum temperature observed on temperature logs.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: VACCINE MANAGEMENT PLAN

DATE DEVELOPED: 9/14
REVIEWED: 11/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 11/15; 6/16; 6/17; 6/18; 6/21; 6/22; 6/23; 6/24

I. POLICY:

The Division of Public Health Services maintains an up-to-date written Vaccine Management Plan that is updated annually.

II. PURPOSE:

To outline proper guidelines for vaccine storage, handling, shipping, receiving, ordering, control, and prevention of vaccine expiration spoilage and waste.

III. GUIDELINES:

A. Key Staff

1. Designate one staff member to be the primary vaccine coordinator and at least one back-up coordinator. The primary vaccine coordinator is responsible for provider oversight of all vaccine management within the office and ensuring all vaccines are stored and handled correctly. The back-up coordinator can assume oversight responsibilities in the absence of the primary coordinator.

2. All changes in key staff must be communicated to the North Carolina Immunization Program (NCIP) as they occur.

3. At a minimum, the primary vaccine coordinator and back-up must complete one educational activity on the VFC program requirements. (Either by attending the Immunization Conference, Regional Immunization Conference, or completing You Call the Shots: Modules 10 and 16 at http://www.cdc.gov/vaccines/ed/youcalltheshots.htm). All training must be documented on the NCIP Employee Education Roster.

4. Staff training should include, but is not limited to, the following topics: screening for VFC eligibility, procedure for receipt of vaccine delivery, daily storage and handling procedures, administering vaccine and transportation of vaccine in an emergency.

VACCINE MANAGEMENT
PLAN
PAGE 2

Clinic Name	Rockingham County Division of Public Health
Address	371 NC 65, Suite 204 Wentworth, NC 27375

Role	Name	Job Title	Home Phone	Cell Phone
Primary	Susan Cox	Immunization Coordinator		336-514-2873
Back-up	Jennifer Love	Clinical Supervisor		336-932-3673
Lead Physician	Dr. Kevin Howard	Medical Director		336-932-5102
Office Staff	Susan Young	Director of Nursing		336-951-7549

Duties of Key Staff Members:

a. Lead Physician

- Complies with all federal vaccine management requirements
- Designates one employee as the practice's primary vaccine coordinator
- Designates one employee as the practice's back-up vaccine coordinator
- Reports changes in key staff to NCIP
- Conducts and documents required orientation and annual training for vaccine management personnel at least annually and as necessary
- Ensures practice's vaccine storage units meet NCIP requirements
- Updates and revises vaccine management plans at least annually and as necessary

b. Primary Vaccine Coordinator

- Completes required NCIP and VFC trainings
- Oversees the practice's vaccine management for routine and emergency situations
- Monitors vaccine storage units
- Maintains NCIP-related documentation in an accessible location

c. Back-up Vaccine Coordinator

- Completes required NCIP and VFC trainings
- Meets all responsibilities described in the primary vaccine coordinator duties when he/she is not available.

B. Vaccine Ordering

1. Order and administer all ACIP –recommended vaccines.

2. Draw up vaccine only at time of administration.

3. Physically distinguish between public and private vaccine stock and maintain complete, accurate and separate stock records.

4. Multi-dose products may be used until expiration date stamped on the vial. Vaccine with expiration date on vial with only month and year may be used through the last day of that month.

5. Do not transfer or borrow vaccine without approval from NCIP.

C. Vaccine Ordering/Inventory Control

1. All vaccine ordering of VFC vaccine will be generated by the Immunization Coordinator or Clinical Supervisor.

2. Orders will be placed every other month or every three months based on NCIR recommendations taking into consideration high volume clinical immunization periods. Extra amount of vaccine will need to be ordered during expected "peak usage" months. The orders will be placed for VFC vaccine through the NCIR. Private orders will be placed on a request form and given to the **purchasing clerk.**

D. Vaccine Storage Units: Locations and Maintenance

1. Refrigerator vaccines must be maintained between 2^0C and 8^0C (35^0F and 46^0F) with an optimum of 5^0C (40^0F) at all times.

2. Freezer temperatures must be maintained between -50^0C and -15^0C (-58^0F) with an optimum of -20^0C (-4^0F) at all times.

3. Vaccines should be stored in separate, stand-alone refrigerator or freezer units.

4. Providers may no longer purchase combination units for vaccine storage. All new purchases must be stand-alone units.

5. Provider must notify the NCIP immediately upon discovering vaccine has been involved in a cold chain failure. If a cold chain failure is suspected, providers must:

- Store vaccine under correct storage conditions in a properly functioning and monitored vaccine storage unit
- Quarantine vaccine. Label vaccine "DO NOT USE" so the vaccine is not administered
- Notify the NCIP immediately after discovery of the incident at 877-873-6247 for assistance

- Document any actions taken on the temperature logs regarding out of range temperatures
- Do NOT discard any vaccine unless directed to do so by the NCIP

6. Post a "DO NOT UNPLUG" sign on the vaccine storage units and circuit breakers. Do not plug unit into ground fault interrupter (GFT) outlets, power strips, or outlets that are activated by switches.

Maintenance/Repair Company	**Contact Name**	**Phone Number**
Chrismon Refrigerator Sales & Service	Mr. Chrismon	336-349-6449

Unit Type	**Location**	**Brand**	**Model**	**Serial Number**	**Date Received**
Refrigerator #3	Pharmacy	Helmer		0964852	
Refrigerator #1	Copy Room	**Thermo Scientific**	**TSX2305PA**	**1143932501231107**	**11/2023**
Freezer #2	Pharmacy	Thermo Scientific	ULT430A21	0113083901170111	1/20/2017
Refrigerator #4	Room 30	Thermo Scientific	REL2304A25	0155989101161221	12/30/2017
Refrigerator #5	Copy Room	Thermo Scientific	TSX2305PA	1161658101200918	11/2020
Freezer #3	Copy Room	Thermo Scientific	T5C1390A	300486396	9/2021

E. Routine Vaccine Maintenance

1. Vaccines should be stored in their original packaging, placed in the middle of the unit with space between vaccine and the sides/back of the unit. Providers may use plastic organizational boxes for inventory control, provided there are holes to allow for circulation.

2. Open only one vial or box of a particular vaccine at a time to control vaccine use and allow easier inventory control. On each opened vaccine vial, indicate on the label the date and time it was reconstituted or first opened. Use tick marks on multi-dose vials to keep track of doses.

3. Order, stock and administer all ACIP-recommended vaccines for the population served.

4. Draw up vaccine only at the time of administration.

5. Practices that serve both VFC and non-VFC children must maintain separate public and private vaccine inventories.

6. All instances of borrowing between VFC vaccine and private vaccine must be recorded, documented, and paid back within 30 days.

7. Expired vaccine must be removed immediately from the storage unit **and replaced** with viable vaccine.

8. Daily tasks:

   Record temperature on each unit at the beginning of the shift and near the end of the shift. Record minimum/maximum reading at the beginning of every shift and clear memory.

9. Weekly tasks:

   Rotate stock so that newer vaccines are stored toward the back of the unit, while those soonest-to-expire are stored in the front. Providers must notify the NCIP of any vaccine doses that will expire before they can be administered at least 4 months before the expiration date to avoid restitution for improper inventory management. Providers must coordinate with the NCIP to transfer and document the transfer of vaccine between providers. Vaccine transfers between providers can occur only after receiving NCIP approval.

10. Monthly tasks:

    - Check the North Carolina Immunization Program website for updates.
    - Conduct an inventory count to reconcile any differences between physical count and NCIR.
    - Check door seals of refrigerator and freezer.
    - Check borrowing and replacement reports to ensure all borrowed vaccine has been replaced within 30 days of the borrowed date.

F. Receiving and Unpacking Shipments

1. Arrange for shipments only when the primary vaccine coordinator or back-up coordinator is available if possible.

2. If the primary coordinator or back-up coordinator is unavailable then any clinical nurse may receive the vaccine. Ensure that packing list is provided to the immunization coordinator/back-up coordinator and they are informed of vaccine delivery upon their return.

3. Keep reception staff current regarding vaccine delivery and train staff to respond to a vaccine delivery appropriately.

4. Upon receipt of vaccine shipment, clinic staff must:

   - Open vaccine package immediately
   - Check the temperature monitor readings
   - Inspect the vaccine and packaging for damage
   - Determine length of time the vaccine was in transit by looking at the packing list

- Immediately store at appropriate temperatures
- Examine quantity, lot number, and expiration dates against invoice

5. If there is an issue with the vaccine shipment or there is a problem with the temperature monitors, providers must contact the NCIP at 877-873-6247.

G. Thermometer Maintenance and Temperature Monitoring

1. Providers must have a calibrated digital data logger thermometer with a probe in glycol with a current certificate issued by an ILAC-accredited laboratory on all units storing vaccine. All certificates must contain model number, serial number, date of calibration, measurement results indicating unit passed testing, and the documented recommended uncertainty within $\pm 1^0$F (0.5^0C). It is the duty of the primary vaccine coordinator to ensure all data loggers in use have a current calibration certificate.

   - Location of certificates of calibration: Room 11 Vaccine Notebook
   - Location of back-up thermometer(s): Room 12 file cabinet

2. Thermometers must be placed in a central area of the unit directly with the vaccine in order to properly measure vaccine temperature. Thermometers should not be placed in the doors, near or against the walls, close to air vents, or on the floor of the unit.

H. Temperature Logs

Provider must manually record temperatures on paper temperature logs regardless of continuing monitoring systems that may be used. The following requirements apply:

- Appropriately trained staff must record finding on a paper temperature log twice a day on all days the clinic is open.
- The log must include the time, date, temperature, and initials of the staff member. The log must also include daily minimum and maximum temperatures.
- The log must be posted on each vaccine storage unit door or nearby in a readily accessible and visible location
- Providers must maintain an ongoing file of paper temperature logs for 3 years

Completed temperature logs are stored in the Temperature Notebook on the bookcase in Room 11.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

OSHA MANUAL
INFECTION CONTROL
INDEX

*For Referral of Employee, Potential Employees and Immigration Applicants with Positive Mantoux Skin Test (TSTs) see TB-1 Policy.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: INFECTION CONTROL PROGRAM OVERVIEW

DATE DEVELOPED: 11/99
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/03; 7/03; 3/04; 5/04; 1/05

INFECTION CONTROL PROGRAM

The Division of Public Health Services has developed and implemented an infection control program to minimize the risk of client and staff exposure to infectious organisms and reduce the consequences resulting from any accidental exposure to infectious pathogens. All staff will receive information and training about the department's infection control program and will provide services according to the policies and procedures established to minimize negative consequences from infections.

The Infection Control policies shall be reviewed at least annually and updated whenever necessary.

All full-time and part-time employees who have occupational exposure to bloodborne pathogens are covered by these policies.

To ensure compliance with the Occupational Exposure to Bloodborne Pathogens; Final Rule 29 CFR Part 1910, 1030.

Health Requirements

The Division of Public Health Services has developed policies relating to health screening of all employees. These requirements include a TB skin test or certification that the employee is free of symptoms of tuberculosis and availability of the Hepatitis B vaccine to all employees at risk of exposure to blood or body fluids. The Rockingham County Department of Public Health does not provide the initial Hepatitis B Vaccination series to contract employees. All individuals employed by other agencies (contract employees or students) who use the Division of Public Health Services as a learning facility and who are classified in categories I or II will be expected to obtain HBV through their employer or school.

Each individual will receive training in the OSHA Bloodborne Pathogen Exposure Plan, prior to performing duties within the Division of Public Health Services, from their individual employer or school.

Education of Staff

All staff will receive education and training relating to infection control and the specific policies of the agency as part of their regular orientation program and throughout their

employment through annual inservice education programs. Orientation will include information on control of infections: etiology, incidence, methods of transmission, signs and symptoms, preventive measure and treatment of hepatitis C, hepatitis B, HIV, and tuberculosis; and specific policies and procedures relating to the access, storage, use and disposal of medical supplies and reusable equipment and other information relating to infection control.

Annual and periodic inservice education programs relating to infection control is mandatory for all staff. Topics for these programs may include updated information about infectious diseases, current research on asepsis and client care techniques or other topics appropriate to the services rendered by staff.

All training records must be kept for six (6) years.

Identification and Monitoring of Client or Staff Infections

The Division of Public Health Services uses the surveillance data to identify the problems or undesirable trends. Data is required to identify if the infection is organization acquired or community acquired. When the infection is organization acquired, the Division of Public Health Services takes steps to identify any common factors related to the organization that could have led to the transmission of the infection. In the interest of early detection and prompt response to potential infections among staff or clients, the health department has adopted specific criteria and procedures to monitor symptoms of potential infections. Appropriate monitoring and implementation of preventive procedures will assist the program to obtain necessary treatment of new infections developed by clients or employees. In addition to ongoing monitoring of infections, the health department will report all illnesses defined by the NC Department of Health and Human Services as reportable and follow public health guidelines relating to these infections.

Surveillance

The Division of Public Health Services will collect data about infections regarding changes in any infection trends of a targeted population. These targeted populations may include: High risk, high volume, or problem prone areas and any specific types of equipment used. Areas for surveillance may be any agency related infection which may be bacteria, lower respiratory tract infections, invasive equipment, etc. Definitions of these infections can be found in the Exposure Control Plan.

Prevention

The Division of Public Health Services develops policies and procedures that instruct the staff, client and caregivers on prevention of transmission of infection. The agency strives to prevent the spread of infection among staff through TB screenings and providing the availability of the HBV vaccine. Staff are instructed on implementation of standard

precautions and the teaching of these preventive measures to the clients/caregivers during orientation and on an annual basis. During orientation and on an as-needed basis, staff members who provide direct client contact have accessible basic personal protective equipment, including a box of gloves, impervious gowns, mask, face shields/goggles, approved antiseptic, sharps container, biohazard cooler, labels, and a resuscitation ventilator mask. A spill kit may be available to use in the event of a spillage. Home visiting staff are responsible for carrying the resuscitation mask on his/her persons during home visits.

Education of Clients and Caregivers

Staff will educate clients and caregivers about general infection control practices and specific precautions relating to any identified infections. These instructions may include information about the transmission of specific diseases, isolation measures, standard precautions, handwashing and handling/disposal of hazardous or medical waste.

Adherence to Federal and State Requirements

All staff will adhere to approved policies and procedures related to the services to be provided. Staff will be responsible for proper cleaning and storage of all equipment used in the provision of their job responsibilities and adherence to all agency, federal and state requirements relating to infection control.

Evaluation of the Infection Control Program

The Infection Control Program will be evaluated on an ongoing basis and results may be reported to the following as trends are identified:

a. Health Director
b. Epi Team
c. Hospital Infection Control Practitioners
d. Rockingham County School Nurses
e. All Rockingham County Physicians
f. Rockingham County Board of Health and Human Services

The Division of Public Health Services strives hard to adhere to the guidelines set forth by the Occupational Health and Safety Administration in order to provide for the safety of its employees. This policy manual is placed in strategic locations throughout the agency in order to be accessible to all employees.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMPLOYEE CATEGORY OF RISK FOR EXPOSURE TO BLOOD AND BODY FLUIDS

DATE DEVELOPED: 11/99
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15

I. POLICY:

The Division of Public Health Services will maintain an exposure control plan that is reviewed and updated annually and as changes occur. The plan must identify employee job classifications at risk of possible exposure to bloodborne pathogens and provide appropriate training to such employees.

II. PURPOSE:

1. To identify all agency positions that have a reasonably anticipated occupational exposure to bloodborne pathogens through contact with skin, mucous membranes, eye or parenteral contact with blood or other infectious materials, such as semen, vaginal secretions, saliva, body fluids where it is difficult or impossible to differentiate between body fluids and cells and fluids containing HIV, HCV and HBV.

2. To ensure compliance with the Occupational Exposure to Bloodborne pathogens; Final Rule 29CFR part 1910.1030, effective March 6, 1992.

III. GUIDELINES:

Scope of Coverage

A. Identification of employee classification for risk of exposure to bloodborne pathogens.

   1. The OSHA standards on bloodborne pathogens apply to all employees that provide hands-on care to client as well as to any non-client care employee who may handle any body fluids such as transporting laboratory specimens, disposing of contaminated materials or employees responsible for cleaning areas that contaminated items may contact.
   2. Positions will be categorized based upon the responsibilities to perform procedures that place them at risk of exposure to bloodborne pathogens.

B. Categories

1. Category I: Actual tasks or potential tasks that involve exposure to blood, mucous membrane, body fluids or tissue, for example, assisting or performing invasive procedures.
2. Category II: Tasks that involve no exposure to blood, body fluids or tissue but may require performing unplanned Category I tasks, for example, employees coming in contact with blood one time per month.
3. Category III: Tasks that involve NO exposure to blood, body fluids, or tissue.
4. Job classifications and category of risk. The Division of Public Health Services establishes, maintains and enforces work practices and standard operating procedures to eliminate or minimize contact with blood or other potentially infectious materials.

    a. Category I - Nursing Management, Health Professional Students, Laboratory Technicians, Physician, Registered Nurse, Licensed Practical Nurse, Medical Office Assistant, Dental Hygienist/ Assistant, Cleaning Staff, Dentist, Physician Extender
    b. Category II - Environmental Health
    c. Category III - Administrative Staff, Nutritionists, WIC Staff, Management Support, Social Workers, Health Educator, Foreign Language Interpreter, Pharmacist, Pharmacy Technicians, PAP Staff
    d. Employees classified in Category I and II are offered the hepatitis B vaccine free of charge. Employees in Category III may choose to receive the hepatitis B vaccine at their expense.
    e. Personal protective equipment will be made available to all employees.
    f. Fluid categories under Universal Blood and Body Fluid Precautions are:

        (1) Body fluids to which universal precautions apply: blood, blood components, e.g., serum, other body fluids containing visible blood, semen, vaginal secretions, tissues, cerebral spinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, saliva secreted during dental procedures.
        (2) Body fluids to which universal blood and blood fluid precautions do not apply (unless there is visible blood): feces, nasal secretions, sputum, sweat, tears, breast milk, urine, vomitus, and saliva.

EMPLOYEE CATEGORY OF RISK FOR EXPOSURE TO BLOOD AND BODY FLUIDS
POLICY
PAGE 3

CODES:

X - MUST DO OR WEAR
S - IF SPILLING ANTICIPATED
* - IF SPLATTERING ANTICIPATED

PROCEDURE	HAND WASHING	GLOVES	GOWN	MASK	FACE SHIELD GOGGLES
1.a. Bleeding, pressure application to control - minimum bleeding	X	X			
b. Spurting blood	X	X	X	X	X
2. Blood glucose testing	X	X			
3. Nebulizer treatment	X	S		X	*
4. Changing Diapers	X	X	S		
5. Changing soiled table covers	X	X	S		
6.a. Clean-up: Incontinent client (feces)	X	X	S		
b. Incontinent client (urine)	X	X	S		
c. Spills of blood/body fluids	X	X	S		
d. Surfaces contaminated by blood/body substances	X	X			
e. CPR	X	X			
7. Direct contact with clients with frequent forceful coughing	X	X	S	X	X
8. Emptying wastebaskets	X	X			
9. Immunizations	X	X	*	*	*
10. Medication administration: Eye, ear, nose drops	X	X			
11. Oral Medication - Nurse Administration: a. Handed to client	X				
b. Placed in mouth by nurse	X	X			
12. Oral/Nasal Care	X	X			
13. Oxygen: Placing of cannula or mask	X				
14. Physical Assessment	X	S	S		
15. Pulse Oximetry	X				
16. Specimen Collection (blood, stool, urine, sputum, wound, pap)	X	X	*	*	*
17. Oral, Tympanic Temperature	X				
18. Urine/Stool Testing	X	X			
19. Vital Signs	X				
20. Bioterrorism Agents	X	X	X	X	X
21. Communicable Disease	X	X	*	*	*

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: INFECTION CONTROL/EXPOSURE CONTROL PLAN FOR EMPLOYEES: BLOODBORNE PATHOGENS

DATE DEVELOPED: 11/99
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/24

I. POLICY:

The Division of Public Health Services' staff members implement policies and procedures for the care of clients with infectious and/or contagious diseases and for infection control practices as appropriate to control the spread of infection and protect individuals from transmission of communicable and infectious disease. The health department will maintain a written exposure control plan that is reviewed and updated annually or as changes occur. The plan must identify employee job classifications at risk of possible exposure to bloodborne pathogens and provide appropriate training to such employees.

II. PURPOSE:

A. To control the spread of infection

B. To protect individuals from transmission of communicable/infectious diseases.

C. To identify all agency positions that have a reasonably anticipated occupational exposure to bloodborne pathogens through contact with skin, mucous membranes, eyes or parenteral contact with blood or other infectious materials, such as semen, vaginal secretions, saliva, body fluid where it is difficult or impossible to differentiate between body fluids and cells and fluids containing HIV, HBV, and HCV.

D. To ensure compliance with the Occupational Exposure to Bloodborne Pathogens; Final Rule 29 CFR Part 1910.1030, and relevant section of the North Carolina Communicable Disease law and rules (G.S. 130A – 144, 15A NCAC 19A .0201 (b) (4) (e) and (f) .0202 (4) and (9)), and .203 (b) (3), and North Carolina Medical Waste Management Law and rules (G.S. 130A – 309.26 and 15A NCAC 13B .1200 to .1207.).

III. GUIDELINES:

Scope of Coverage

A. Identification of employee classification for risk of exposure to bloodborne pathogens**.**

1. The OSHA standards on bloodborne pathogens apply to all employees that provide direct, hands-on care to clients as well as to any non-client care employee who may handle any body fluids such as transporting laboratory specimens, disposing of contaminated materials or employees responsible for cleaning areas that contaminated items may contact. Health Care Personnel (HCP) are defined as persons (employees, students, contractors, attending clinicians, public safety workers, or volunteers) whose activities involve contact with clients or with blood or other body fluids from clients in a healthcare, laboratory, or public-safety setting.

2. All positions at the Division of Public Health Services will be categorized according to the position's responsibilities that place them at risk for exposure to bloodborne pathogens. An exposure that might place a HCP at risk for HBV, HCV, or HIV infection is defined as percutaneous injury (a needlestick or cut with a sharp object) or contact of mucous membrane or non-intact skin (exposed skin that is chapped, abraded or afflicted with dermatitis) with blood, tissue, or other body fluids that are potentially infectious.

3. The following fluids are considered potentially infectious:

   a. Cerebrospinal fluid
   b. Synovial fluid
   c. Pleural fluid
   d. Peritoneal fluid
   e. Pericardial fluid
   f. Amniotic fluid
   g. Semen
   h. Vaginal secretions
   i. Saliva secreted during dental procedure

4. Feces, nasal secretions, saliva, sputum, sweat, tears, urine, vomitus, and breast milk are not considered potentially infectious unless they contain visible blood.

5. HBV and HCV have been demonstrated to survive in dried blood at room temperature on environmental surfaces for more than 1 week.

6. HCV can be transmitted through occupational exposure to blood. (MMWR Vo. 25/No. 38, September 26, 2003)

7. Information about primary HIV infection indicates that systemic infection does not occur immediately, leaving a brief window of opportunity during which post-exposure antiretroviral intervention might modify or prevent viral replication.

   Initiation of antiretroviral PEP soon after exposure might prevent or inhibit systemic infection.

   (MMWR Vol. 50/No. RR-11, June 29, 2001)

B. The Division of Public Health Services' staff members will implement infection control procedures with regard to clients, staff, and their environment.

C. In order to serve the client with a communicable disease, there must be adequate facilities to provide care while protecting staff and the client's family.

D. The Division of Public Health Services shall provide employees with appropriate personal protective equipment which may include, but not limited to: gloves, impervious gowns, masks, face shields/goggles, antiseptic, disinfectant cleaner, spill kit and resuscitation ventilator mask.

E. Precautions for Staff Members:

1. <u>Standard Precautions</u>

   a. All hands-on employees must follow the "Universal Blood and Body Fluid Precautions" developed by the Centers for Disease Control (CDC) and published in 29 CFR Part 1910.1030, Occupational Exposure to Bloodborne Pathogens. The Standard Precautions concept assumes that all blood and blood-contaminated body fluids are potentially infectious.
   b. The Division of Public Health Services' staff members implement infection control procedures with regard to clients, staff and their environment.
   c. Infectious diseases are those diseases that can be transmitted by a person who harbors an infectious agent. An infection can also be spread by contaminated surfaces, equipment, inanimate objects, blood, body fluids, water droplet spray and vectors.

d. Each health care worker will be expected to follow all infection control guidelines. All clients must be considered as potentially infected.

e. The Division of Public Health Services shall provide mandatory in-service education to all employees on infection/bloodborne pathogen exposure control policies and procedures. All new employees will receive bloodborne pathogen training during the County orientation. Employees shall be updated as new information is made available and all training will be repeated on a yearly basis. Written documentation verifying each employee's orientation to these policies and procedures shall be maintained in the Staff Development office or a designated area. The employee's signature on this document shall acknowledge that they understand and agree to follow all infection control policies and procedures.

f. Hepatitis B vaccine shall be provided to all employees who are categorized as performing tasks that involve potential for mucous membrane or skin contact with blood, body fluids, or tissues, or potential for spills or splashes of them.

The first dose of vaccine is to be made available to employees, who have occupational exposure, within 10 working days of initial assignment, unless the employee has previously received the complete Hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

Hepatitis B vaccine can be administered at the same time as other vaccines with no interference with antibody response to the other vaccines.

If the vaccination series is interrupted after the first dose, the second dose should be administered within 1 month or as soon as possible. The second and third doses should be separated by an interval of at least two months. If only third dose is delayed, administer as soon as possible.

HCP who have contact with clients or blood and are at ongoing risk for percutaneous injuries should be tested 1-2 months after completion of the 3 dose vaccination series.

-persons who do not respond to the primary vaccine series should COMPLETE A SECOND 3 DOSE VACCINE SERIES.

-when revaccinated retest after the second series.
-persons who prove to be Hbs Ag - positive should be counseled how to prevent HBV transmission to others and regarding the need for medical evaluation.
-non-responders to vaccination who are Hbs Ag negative should be considered susceptible to HBV infection and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parental exposure to Hbs Ag positive blood.

Booster doses of Hepatitis B vaccine are not necessary, and periodic serologic testing to monitor antibody concentrations after completion of vaccine series is not recommended (NC Hepatitis B Public Health Program Manual/Vaccination, February 2012).

Any blood or body fluid exposure sustained by an unvaccinated, susceptible person should lead to the initiation of the Hepatitis B vaccine series.

Employees who decline Hepatitis B vaccine are required to sign a Hepatitis B Vaccine Declination Form, and have the option of taking the vaccine at a later date if occupational exposure continues and/or occurs.

Employees having received HBV prior to employment with the Division of Public Health Services must supply documentation of dates received.

To comply with Standard Operating Procedures for Prevention of Disease(s) caused by Bloodborne Pathogens the Division of Public Health Services has developed written exposure determinations and maintains a list of all job classifications in which employees have occupational exposure to bloodborne pathogens. All job tasks and procedures are classified into one of three categories to facilitate exposure determination.

<u>Exposure Determination includes</u>:

Category I: Tasks that involve potential for mucous membrane or skin contact with blood, body fluids, or tissues, or potential for spills or splashes of them.

* Nursing Management
* Health Professional Students
* Lab Technicians

* Physician
* Physician Extenders
* Registered Nurse, Licensed Practical Nurse
* Medical Office Assistant
* Dental Hygienist/Assistant
* Cleaning Staff
* Dentist

Category II: Tasks that involve no exposure to blood, body fluids, or tissues, but employment may require performing unplanned Category I tasks.

* Environmental Health Staff

Category III: Tasks that involve no exposure to blood, body fluids, or tissues, and Category I tasks are not a condition of employment.

* Administrative Staff
* Nutritionist and WIC Staff
* Management Support Staff
* Social Worker
* Health Educator
* Foreign Language Interpreter
* Pharmacist, Pharmacy Technicians, PAP Staff

g. The Rockingham County Division of Public Health shall provide employees with appropriate personal protective equipment which may include, but not be limited to: gloves, gowns or aprons, masks, eye protection and face shields.

h. The categories of infections monitored through Rockingham County Department of Public Health:

(1) Organization - related infection (acquired)
(2) Nosocomial - hospital related
(3) Community

i. CDC and the Occupational Safety and Health Administration (OSHA) have also identified other body fluids which are considered potentially infectious and to which Standard/Universal Precautions also apply. These are: semen, vaginal secretions, cerebrospinal fluid (CSF), synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and any fluids in which differentiation of body fluid types is difficult or impossible.

F. Definition of Exposure to Blood or Body Fluids:

1. Accidental parenteral inoculation with significant blood or blood contaminated instruments such as needles or other sharp instruments.

2. Parenteral needlesticks or cut, mucous membrane splash to the eye or mouth, or a cutaneous exposure.

3. Mucous membranes or open skin lesions (wound) contaminated with significant blood or certain body fluids (amniotic, pericardial, peritoneal, pleural, synovial, cerebral spinal, semen, vaginal or any body fluid visibly contaminated with blood).

G. Definitions: OSHA terms utilized at the Division of Public Health Services for the Exposure Plan for Bloodborne Pathogens (OSHA Regulations 29 CFR 1910.1030 - *Bloodborne Pathogens*):

Blood means human blood, human blood components, and products made from human blood.

Blood-borne Pathogens	Pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, Hepatitis B virus (HBV) human immunodeficiency virus (HIV), Hepatitis C virus (HCV).
Clinical Laboratory	A workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials.
Contaminated	The presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.
Contaminated Laundry	Laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.
Contaminated Sharps	Any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination	The use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.
Engineering Controls	Controls (e.g., sharps disposal containers) that isolate or remove the bloodborne pathogens hazard from the workplace.
Exposure Incident	A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.
Handwashing Facilities	A facility providing an adequate supply of running portable water, soap and single use towels or hot air drying machines.
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
Needleless system	A device that does not use needles for: (1) The collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established; (2) The administration of medication or fluids; or (3) Any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps.
Occupational Exposure	A reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Other Potentially Infectious Material	(1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV, HCV or HBV - containing cell or tissue cultures, organ cultures, and HIV, HCV or HBV containing culture medium or other solutions; and blood, organs or other tissues from experimental animals infected with HIV, HCV or HBV.
Parenteral	Piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts and abrasions.
Personal Protective Equipment	Specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) are not intended to function as protection against a hazard. They are not considered to be personal protective equipment.
Regulated Waste	Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.
Sharps with Engineered sharps injury protection	A non-needle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medication or other fluids, with a built-in safety feature or

	mechanism that effectively reduces the risk of an exposure incident.
Source Individual	means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital, and clinic clients, clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.
Sterilize	The use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.
Universal Precautions	All human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, HCV and other bloodborne pathogens.
Work Practice Controls	Controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

H. Methods to Control Exposure:

1. All client care staff will practice Standard Precautions at all times.

2. All Category I and Category II employees shall be eligible to receive Hepatitis B vaccine, at no cost and at a reasonable time and place, within 10 days of employment according to the Employee Health Requirements for Hepatitis B Vaccination. All individuals, employed by other agencies or students who use the Division of Public Health Services as a learning facility will be expected to have obtained HBV through their employer or school.

3. All employees will receive training regarding exposure control measures on hire and annually thereafter. Training will include:

   a. An explanation of the Bloodborne Pathogen Standard.
   b. Epidemiology and symptoms of Hepatitis B, Hepatitis C, and HIV.

c. Modes of transmission of bloodborne pathogens.
d. Review of the agency's Exposure Control Plan.
e. Methods for recognizing tasks that may involve exposure to blood or other potentially infectious material.
f. Use and limitations of engineering controls, work practices and personal protective equipment in the prevention and reduction of exposure to bloodborne pathogens.
g. Types, selection, proper use, location, removal, handling, decontamination and disposal of personal protective equipment.
h. The efficacy, safety, method of administration, availability and benefits of Hepatitis B Vaccine.
i. Review of post-exposure procedures including appropriate actions to take, persons to contact in an emergency, method for reporting incidents and medical follow-up of an exposure. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available.
j. Explanation by the agency of the signs, labels and coding regulations and requirements by the OSHA standard.
k. Staff member infection control procedures include, but are not limited to the following:
    (1) Frequent handwashing by employees:
    -before and after the provision of direct client care
    -after handling soiled or contaminated materials
    -after going to the toilet
    -after removing gloves
    -the Division of Public Health Services shall provide handwashing facilities which are readily accessible to employees.
    -The Division of Public Health Services shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.
    -When provision of handwashing facilities is not feasible, the Division of Public Health Services shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleansers or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

(2) Covering nose and mouth when coughing and sneezing.

(3) Covering open sores or cuts on fingers or hands with clean bandages.

(4) Avoid needlesticks and injuries from sharp objects. Do not recap, break or bend needles. Disposable needles and sharps must be placed in a labeled or color-coded sharps container for biohazard leak proof on the sides and bottom, and puncture-resistant for disposal. Sharp containers are not to be filled past 2/3 full. Once containers are 2/3 full the lid is to be taped, and the container then placed in the agency hazardous waste box for pickup and disposal.

(5) During a procedure where there is no exposure to blood, such as withdrawing medications or pharmaceuticals from a vial, it would not be necessary to implement the use of engineering controls or safety needle device usage. (ex: drawing up diluent or medication.) The professional discipline would then change the needle to a safety needle device for medication administration.

(6) Appropriate personal protective equipment should be worn when contact with blood/body fluids is anticipated.

- (a) gloves–when touching blood/body fluids, mucous membranes, and non-intact skin of clients when handling items or surfaces soiled with blood/body fluids.
- (b) gowns/lab coats or clinic jackets–when splashes or soiling with blood/body fluids is likely.
- (c) resuscitation mask–to minimize the need for emergency mouth-to-mouth resuscitation mouthpieces, resuscitation bags, or other ventilation devices are available for use when the need for resuscitation is predictable.
- (d) masks, glasses, goggles/face shields–during procedures that are likely to generate splashes, sprays, spatter or droplets of blood or blood/body fluids into the mouth, nose, ears, or eyes.
- (e) appropriate wound and skin dressing techniques.

(f) Use of PPE: The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was in the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgment, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future.

(g) Accessibility: The employer shall strive to ensure that appropriate personal protective equipment in the appropriate sizes is readily accessible at the worksite or is issued to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

(h) The Division of Public Health Services has established and maintains a record keeping system that consists of:

(1) a confidential medical record for each employee who performs Category I and II tasks.

(2) training records including content or summary of training, faculty and attendance, date of training, name and qualifications of persons conducting training, and names of all attending. Training records are maintained for 6 years from the date on which training occurred.

(i) Cleaning, Laundering, and Disposal: The employer shall clean, launder, and/or dispose of personal protective equipment at no cost to the employee.

(j) Repair and Replacement: The employer shall repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee. If a garment(s) is penetrated by blood or other potentially infectious materials, the garment(s) shall be removed immediately or as soon as feasible.

(k) When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage, washing, decontamination or disposal. All personal protective equipment shall be removed prior to leaving the work area.

(7) Appropriate handling and disposal of waste products: disposable items such as gloves, gown, under pads, etc., should be double bagged and tied shut. The bag should be placed out for normal trash pick-up.

(8) If the same measures are used for anticipated contact with other body fluids not listed specifically by the CDC as potentially infectious for bloodborne pathogens (i.e., sputum, feces, urine, saliva, vomitus, sweat, tears and breast milk), then transmission of most infectious diseases can be avoided.

(9) Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is potential for occupational exposure.

(10) Food and drink shall not be stored in refrigerators, freezers, shelves, cabinets, or counter tops where blood or other potentially infectious materials are stored.

(11) Specimens of blood or other potentially infectious materials are placed in designated leak-proof containers for handling, storage and transport.

(12) Transporting Specimens:
All client specimens must be considered potentially infectious and will be handled using standard precautions. Specimens should be properly labeled and placed in a leak-proof container.

(a) Care will be taken when collecting and handling specimens to avoid contamination of the outside of the container. All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances. Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

(b) The primary container should have a leak-proof, labeled or puncture resistant closure and be placed in an impervious container. Blood will be labeled with biohazard labels.

(c) Lab specimens should be enclosed in a biohazard labeled plastic bag and transported in a biohazard container. The impervious container should be placed in a stable area during transportation preferably on the floor behind the seat. Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping. If outside contamination of the primary container occurs, the primary container shall be placed within a second container which prevents leakage during handling, processing, storage, transport, or shipping and is labeled or color-coded.

(d) Labels: should be attached to containers of regulated waste refrigerators and freezers containing blood or other potentially infectious materials, and containers used to store, transport, or ship blood or other potentially infectious materials. Bloodborne pathogens warning labels must be fluorescent orange in color and have the biohazard sign and word.

I. Precautions for Clients/Caregivers - Definition of Infections:

1. The spread of infectious diseases to the family or other caregivers can be limited by good personal hygiene principles. Some

caregivers may need more information regarding mode of transmission of the causative infectious agent, the infective material requiring special handling, and the proper use of clothing if needed. The Division of Public Health Services employees provide information to clients and caregivers regarding infection control.

a. Enterics - Gastrointestinal

A client who has diarrhea or who has been diagnosed with an enteric pathogen (Salmonella, Shigella, Hepatitis A, etc.) should pay strict attention to handwashing after each bowel movement. Likewise, the client's caregiver should be instructed in the importance of handwashing after cleaning the client, and particularly, before eating or preparing food. It may be helpful for the caregiver to wear gloves if cleaning up the stool of the client or soiled clothes and linen, but not completely necessary if proper handwashing is performed when these tasks are finished. Soiled linens may be washed as usual laundry, but before washing, they should be placed in a plastic bag or separate laundry basket. Decontaminate shared bathrooms with routine hygiene measures. If soiled with stool, the caregiver should take care to clean the spill promptly with soap and water, as well as a disinfectant product. Handwashing should again be instructed after cleaning.

b. Respiratory Disease

Respiratory diseases such as tuberculosis, measles (Rubeola), German measles (Rubella), pneumonia, mumps, pertussis, meningitis and influenza are spread by airborne droplets. Therefore, clients with these diseases should be confined to one room as much as possible. Caregivers for these clients should check their immunization status or their history of the disease. Those who are not immune or are not sure should, if possible, refrain from direct client care throughout the communicable period. If this is not possible, the caregiver should wear a mask while performing direct care. Gloves should be worn for any contact with respiratory secretions and articles.

A client with a respiratory infection, purulent sputum or frequent coughing should be taught to cover the mouth and nose with a tissue when sneezing or coughing, and to promptly dispose of the tissue in plastic trash bag and disposed as general trash.

Many respiratory diseases may also be transmitted by direct contact of respiratory secretions with hands and then transmitted to the mouth, nose, or eyes. Therefore, handwashing in conjunction with "Standard Precautions" must be emphasized for respiratory precautions as well.

Pregnant women susceptible to Rubella should not take care of clients with Rubella.

A client with tuberculosis will generally have already begun antimicrobial treatment. The caregiver should help insure that the client takes his or her anti-tuberculosis medications as prescribed. To prevent the spread in the household, the client should cover his/her mouth if coughing. Caregivers and close contacts should be screened for possible infection by skin testing through their doctor or health department.

Respiratory isolation is required for clients with pulmonary or laryngeal tuberculosis who have a positive sputum smear or a chest x-ray that strongly suggests active TB. For these clients, NIOSH approved respiratory masks should be worn by caregivers whenever cough inducing procedures are being done or the client is transported in a closed vehicle.

Temporary relocation should be considered for immunocompromised persons or young children living in the home.

c. <u>Sexually transmitted diseases (gonorrhea, syphilis, herpes)</u>
Caregivers with sexual contact with a client should be instructed on safe sex practices and any treatment that may be available. Caregivers should be instructed to use gloves if touching herpetic or syphilitic lesions or if in contact with any infective secretions.

d. <u>Infected wounds, scabies, decubiti</u>
Caregivers of clients with infected or draining wounds or decubiti should be reminded of stringent handwashing practices. Caregivers may use gloves when handling potentially infective material, although this is not absolutely necessary if good handwashing is performed. An over-gown or apron should be worn by a caregiver if in direct contact with a client diagnosed with scabies. Good hygiene measures are sufficient for environmental decontamination and handling of laundry. Be sure client is receiving treatment for scabies and following protocol as ordered.

e. Bloodborne infections (Hepatitis B, Hepatitis C, HIV/AIDS)
Clients with bloodborne pathogens should be handled with the same "Standard Precautions" used by staff members and instruction should be given for these precautions in the home. They should receive instruction regarding the following:

(1) needles or sharps generated by the client should be placed in puncture resistant container (coffee cans, bleach bottles) (found in the home) - when containers are 2/3 full, tape lid tightly closed and may be disposed of in general trash.

(2) use gloves when handling any blood or other body secretions, open wounds, or when handling soiled clothing or linens especially if the caregiver has cuts or abraded skin. Gloves should be removed when contaminated, followed by good handwashing. Use aprons when changing grossly soiled linens or cleaning up large spills. Avoid splashes to the face of blood or other body fluids from the infected client. Gloves should be worn when cleaning up blood spills.

(3) clean spills with soap and water and a disinfectant product. Employees of the agency use a spill kit or a disinfectant which is appropriate for the spill.

(4) soiled linens may be washed as routine laundry but should be stored in a leak proof container such as a plastic bag or separate laundry basket. Gloves should also be worn when handling soiled linens.

(5) It is recommended that household and sexual contacts of Hepatitis B carriers be tested for HBV and if susceptible, be vaccinated.

J. Environmental infection control procedures include, but are not limited to the following:

1. Maintaining a clean work environment, for example, by maintaining clean counters, tables, and shelves

(a) all equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials.

(b) contaminated work surfaces shall be decontaminated with an appropriate disinfectant after:
*completion of procedures

*immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials
*and at the end of the work shift if the surface may have become contaminated since the last cleaning.

(c) protective coverings, such as paper over the exam tables shall be removed and replaced as soon as feasible when they become contaminated or at the end of the work shift if they may have become contaminated during the shift.

(d) all bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

(e) broken glassware which may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dustpan, tongs, or forceps.

2. Covering food by closing cartons and replacing covers.

3. Refrigerating food promptly as appropriate.

4. Rinsing cans and bottles before disposal in the garbage.

5. Washing garbage cans, dirty pails, and trashcans with hot soapy water.

6. Disposing of garbage properly in trashcan with liners.

7. Cleaning all areas of bathroom, especially around toilet base.

8. Keeping clean and dirty items separate.

9. Using sterile items that are not outdated.

10. Contaminated linen soiled with blood, body fluids, secretions, and excretions should be handled, transported and processed in a manner that prevents skin and mucous membrane exposures, contamination of clothing and avoids transfer of microorganisms to other clients and environment.

11. Keeping the client environment, clean, neat, and orderly as possible.

12. Instructing client/caregiver to regularly clean client supplies, such as commodes, bedpans, urinals, and suction machines.

13. Contaminated non-disposable equipment (ex: computers, telephones, EKG machine, etc.) that may become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment or portions of such equipment is not feasible.
    (a) If feasible, the Division of Public Health Services' employee shall decontaminate the non-disposable equipment with approved cleaning/decontamination agents.
    (b) If employee cannot decontaminate the equipment completely, then biohazard labels are placed on the areas of contamination on the equipment prior to shipping to company for service.
    (c) The Division of Public Health Services shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, prior to handling, servicing, or shipping so that appropriate precautions will be taken.

K. The Division of Public Health Services follows the North Carolina medical waste management laws and rules except when the OSHA standard preempts the North Carolina rules because the state rules are less restrictive.

1. North Carolina regulated medical waste is blood and body fluids in individual containers in volumes greater than 20 ml; microbiological waste, such as laboratory cultures and stocks; and pathological waste such as human tissue, organs or body parts. These three types of waste must be treated (rendered sterilization, or sanitary sewage disposal for bulk blood greater than 20 ml per container) prior to disposal with other general solid waste.

    a. Sharps, including contaminated needles, scalpels, plastic slides and cover slips, broken glass and capillary tubes, ends of dental wires, and other contaminated objects that can penetrate the skin, are regulated medical waste and must be: packaged in a biohazard-labeled (fluorescent orange, orange-red with lettering or symbols in contrasting color) or red container that is rigid, closable puncture-resistant and leak-proof (when in an upright position).
    b. Sharps containers must be located close to the work areas and replaced when 2/3 filled. Staff will check containers

daily for overfilling. When containers are 2/3 full they are sealed by clinic personnel, placed in container provided by the Hazardous Waste Disposal Company to be picked up monthly.

c. During removal of sharps containers from areas of use, they must be closed and placed in a second biohazard labeled, leak-proof container or a red plastic bag (160 lb. burst strength polyethylene), if there is the possibility of leakage.

2. To avoid unnecessary employee exposure to small volumes of blood less than 20 ml in individual containers, such as laboratory vacuum tubes, they should not be emptied. Containers of less than 20 ml of blood that are to be discarded and stored while awaiting off-site transport must be either stored in a secure area, restricted to authorized personnel or packaged in a container suitable for sharps, or in a plastic bag that is placed in a rigid biohazard-labeled fiberboard box or drum.

   a. The Division of Public Health Services contracts for disposal of the agency's regulated medical waste.
   b. Contaminated disposal items, such as dressing, drapes, etc., that would release blood or body fluids in a liquid or semi-liquid state if compressed or items that are caked with dried blood are regulated waste as defined by OSHA. Regulated waste does not require treatment and may be disposed of as general solid waste.
   c. However, while onsite, blood-soaked or caked items must be discarded, stored and transported in closable, leak-proof, biohazard labeled containers.

3. As defined by OSHA, contaminated laundry means laundry that is soiled with blood or body fluids or that may contain sharps.

   a. When handling contaminated laundry, employees are to practice Standard Precautions, including wearing gloves. Contaminated laundry is to be handled as little as possible, with minimum agitation.
   b. Contaminated laundry must be placed in biohazard-labeled, leak-proof containers wherever it is generated. It is not to be stored or rinsed at the location where it is used.
   c. Although contaminated laundry must be handled more carefully and stored in labeled bags, it can be washed with the regular laundry.

d. The Division of Public Health Services contracts for janitorial cleaning services and will offer to provide training in Standard Precautions as needs arise.

L. The Division of Public Health Services will report any exposure to communicable disease, bloodborne pathogen or Hazardous Waste to the County Safety and Risk Manager.

The report or exposure form will be completed by identifying:

1. The type of exposure
2. Description of the incident
3. Conditions of exposure
4. Source of information
5. PPE used
6. Names of people potentially exposed
7. Instructions given to the employee
8. Follow-up protocol
9. Signature of understanding or signature of refusal for follow-up

According to 29 CFR 1910.1020 employers shall establish and maintain an accurate record for each employee with occupational exposure. The record must contain:

1. The employee's name and date of birth.
2. The employee's Hepatitis B vaccination status including dates and any medical records related to the employee's ability to receive vaccinations.
3. The results of all examinations, medical testing, post exposure evaluation, and follow-up procedures.
4. A copy of the healthcare professional's written opinion.
5. A copy of any specific information provided to the healthcare professional.

Medical Records - All health-related records and exposure records must be kept for the duration of employment plus 30 years.

CONFIDENTIALITY - The employer shall ensure that employee medical records are:

1. Kept confidential - not disclosed or reported without the employee's written consent to any person within or outside the workplace except as required by this section or as may be required by law.
2. Employer shall maintain the record for at least the duration of employment + 30 years in accordance with the standard 29 CFR 1910.20.

M. Standard Procedures for Employee Exposure to Bloodborne Pathogens:

When an employee has an exposure:

1. Employees are required to:

   a. Remove contaminated personal protective equipment and place it in a red or biohazard labeled bag.
   b. Wash exposed areas (hands and other skin surfaces) with soap and water. Immediately flush exposed mucous membranes with water, and, if exposed, flush eyes with large amounts of cold water for 15 minutes using eyewash located in lab work-up room on the first floor.
   c. Immediately report exposure incident to the direct supervisor and County Safety and Risk Manager. If the exposure occurs after 5:00 p.m. or on a weekend or holiday, the employee should immediately notify their supervisor. The County Safety and Risk Manager must also be notified.

      Once the County Safety and Risk Manager has been notified, **follow policy IC-17 Employee (Health Care Personnel) Follow-Up for Exposure to Blood/Body Fluids.**

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

BLOODBORNE AND AIRBORNE PATHOGEN TRAINING

1. Copy of the Standard 29 CFR 1910.1020
2. Explanation of the modes of transmitting bloodborne pathogens.
3. Explanation of the epidemiology and symptoms of HBV, HCV, and HIV.
4. An explanation of the employer's written exposure control plan.
5. How to recognize activities with exposure element.
6. Explanation of the use and limitations of controls and equipment.
7. Hepatitis B vaccination protocol and requirements.
8. Explanation of emergency procedures.
9. Explanation of post-exposure evaluation/follow-up procedures.
10. Signs and labels and/or color-coding requirements.
11. Question and answer session.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: WORK RESTRICTIONS FOR EMPLOYEES WITH INFECTIOUS DISEASES

DATE DEVELOPED: 7/03
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15

I. POLICY:

Staff experiencing an infectious disease will comply with recommended work restrictions whenever there is the nature and severity of the disease and a degree of risk of transmission of the disease to other staff, clients or caregivers.

II. PURPOSE:

To protect staff and clients from infectious disease.

III. GUIDELINES:

A. All employees and contract staff are expected to be knowledgeable about the transmission of communicable diseases.

B. Employees and contract staff are expected to report the following information to their immediate supervisor:

1. Temperature of $\geq$ 101 degrees.

2. Sudden onset of diarrhea lasting 48 hours or longer.

3. Nausea and vomiting.

4. Symptoms of tuberculosis (TB) disease.

5. Open and draining area that cannot be covered.

6. Known exposure to an infectious disease that the staff person could transmit during the incubation period.

7. Known infectious disease such as common cold, influenza, hepatitis A, upper respiratory infection, measles or chickenpox.

8. Taking an antibiotic for less than 24 hours or antivirals for less than 48 hours for a contagious illness (e.g., upper respiratory infections).

9. If an employee exhibits symptoms of a milder nature that would not normally impede his/her ability to provide client care, it is recommended that he/she utilize personal protective equipment, such as gloves, masks, etc., as deemed appropriate.

10. Always take into consideration the nature of the client's health status. The employee will rearrange his/her schedule to avoid seeing those clients who are at high risk due to a depressed immune system whenever possible.

C. Employees and/or contract staff with any infectious disease will be allowed to continue work as long as they are performing satisfactorily and do not present a risk to themselves, clients and/or other staff.

1. Employees are encouraged to remain at home during periods of acute (sudden onset) illness.

2. In questionable situations the employee's direct supervisor will determine whether the employee may continue with their regular duties or be subject to work restrictions.

3. Reasonable accommodations will be made to find suitable work for the employee as long as there is no undue hardship to the agency.

D. Immediate supervisors are responsible for the following actions with regard to employees who are ill:

1. Encourage the employee to seek medical care through the physician of his/her choice.

2. Advise and instruct the employee concerning any work restrictions using the references on restrictions associated with infectious disease.

3. Be alert for possible ways to accommodate and support the employee's needs within the agency.

4. Maintain contact with the employee and/or the employee's physician, as appropriate, regarding the employee's health status.

5. May require that the employee have a statement from the physician allowing the employee to return to work.

E. The following table is a summary of suggested work restrictions from the CDC for healthcare personnel <u>exposed</u> to or <u>infected</u> with infectious diseases of importance in healthcare settings.

WORK RESTRICTIONS FOR EMPLOYEES WITH INFECTIOUS DISEASES POLICY
PAGE 3

Disease/Problem	Work Restriction	Duration
Conjunctivitis	Patient contact and patient's environment	Until discharge ceases
Diarrhea (with or without nausea and/or vomiting) Acute (sudden onset with no confirmed dx) Convalescent stage of confirmed disease	No patient contact No patient contact	Until symptom free for at least 24 hours Consult CD Manual
Hepatitis A	No patient contact	Until 7 days after jaundice onset
Hepatitis B (acute)	Perform no exposure prone invasive procedure	Until Hepatitis B e-antigen is negative
Hepatitis C (acute)	Perform no exposure prone invasive procedure	Unresolved issue
Herpes simplex Genital Hands Orofacial	 No restriction No patient contact Restrict from care of high-risk patients	 Until lesions heal
HIV	Perform no exposure prone invasive procedure	
Measles Active Post exposure- unvaccinated person	Exclude from duty Exclude from duty	Until 7 days after rash appears From 5th day after 1st exposure thru 21st day after last exposure
Meningococcal infections	Exclude from duty	Until 24 hours after start of recommended therapy
Mumps Active Post exposure (unvaccinated person)	Exclude from duty Exclude from duty	Until 9 days after onset of parotitis From 12th day after 1st exposure thru 26th day after last exposure
Pediculosis (head lice)	No patient contact	Until treated and lice/nit free
Pertussis Active Post exposure No symptoms Symptomatic	Exclude from duty None, prophylaxis recommended Exclude from duty	From beginning of catarrhal stage thru 3rd week after onset of paroxysms or until 5 days after start of treatment Until 5 days after start of recommended treatment
Rubella Active Post exposure (unvaccinated person)	Exclude from duty Exclude from duty	Until 5 days after rash appears From 7th day after 1st exposure thru 21st day after last exposure
Scabies	No patient contact	Until cleared by medical evaluation
Staph aureus infection-draining lesions	No patient contact	Until lesions resolve
Streptococcal infections group A	No patient contact	Until 24 hours after start of recommended therapy

Disease/Problem	Work Restriction	Duration
Tuberculosis		
Active disease	Exclude from duty	Until proved noninfectious
PPD converter	No restriction	
Varicella		
Active	Exclude from duty	Until all lesions dry and crust
Post exposure	Exclude from duty	From 10th day after 1st exposure thru 21st day (28th day if VZIG given) after last exposure
Zoster		
Localized, in health person	Cover lesions, no care of high risk patients (pregnant, neonates, immunocompromised patients, eczema)	Until all lesions dry and crust
Generalized or localized in immunosuppressed person	Restrict from patient contact	Until all lesions dry and crust
Post exposure	Restrict from patient contact	From 10th day after 1st exposure thru 21st day (28th day if VZIG given) after last exposure
Viral respiratory infections, acute febrile illness	Exclude from care of high risk patients and during community outbreaks of RSV and influenza	Until acute symptoms resolve

Source: CDC Personnel Health Guideline, Volume 26, Number 3, pages 299-301, Table 3. Published simultaneously in AJIC: American Journal of Infection Control (1998; 26:289-354) and Infection Control and Hospital Epidemiology (1998; 19:407-63)

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: HAZARDOUS COMMUNICATION PLAN

DATE DEVELOPED: 4/08
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The Division of Public Health Services will provide employees a place of employment free from recognized hazards that are causing or likely to cause death or serious injury to the employee per OSHA Standard NC Section 5(a)(1)(2).

II. PURPOSE:

To communicate hazardous substances within the workplace to the employee.

III. GUIDELINES:

A. Employee Information and Training

The Division of Public Health Services' supervisors shall provide employees with information and training on hazardous substances in their work area at the time of their initial assignment or orientation, and whenever a new hazard is introduced into their work area.

Whenever a new or revised safety data sheet is received, such information shall be provided to employees on a timely basis if the new information indicates significantly increased risks to, or measures necessary to protect employee health as compared to those stated on SDS previously provided.

When training employees who may be exposed to hazardous substances, the Division of Public Health Services in coordination with the managers and/or supervisors shall ensure that each of the following hazard communication training requirements are covered:

a. Employees shall be trained in the physical and health hazards of substances in the work area, and the measures they can take to protect themselves from these hazards including specific procedures the agency has implemented to protect employees from exposure to hazardous substances, such as appropriate work practices, emergency procedures, and personal protective equipment to be used;

b. Employees shall be trained in the details of the hazard communication program developed, including an explanation of the labeling system and the safety data sheet, and how employees can obtain and use the appropriate hazard information.

B. Information

a. Employees shall be informed of their right:

1) To personally receive information regarding hazardous substances to which they may be exposed.
2) To have their physician receive information regarding hazardous substances to which the employee may be exposed.
3) Against dismissal or other discrimination due to the employee's exercise of the rights afforded pursuant to the provisions of the Hazardous Substances Information Act.

b. Employees shall be informed of any operations in their work area where hazardous substances are present; and

c. Employees shall be informed of the location and availability of the written hazardous communication program and Safety Data Sheets (SDS).

C. Container Labeling

All containers of hazardous substances shall be labeled. The agency's supervisors are responsible for ensuring that ALL containers of hazardous materials used in their areas shall be labeled, tagged, or marked with the following information:

- Identity of the hazardous substance(s)
- Appropriate hazard warnings
- Name and address of manufacturer, importer, or other responsible party

Employees shall not remove or deface existing labels on incoming containers of hazardous substances.

D. Safety Data Sheets

The process to ensure hazardous awareness and communication centers on the effective dissemination of appropriate information, and the principle vehicle through which this occurs is the manufacturer's Safety Data Sheet

(SDS), a guide containing important safety related information on hazardous materials.

A Safety Data Sheet (SDS) gives detailed information on how to:

- Store, handle, and use a product in a safe manner
- What to do should an emergency situation occur
- The chemical and physical properties of a product
- A list of all hazardous ingredients

The SDS provides employee/user everything they need to know to work safely with the product and should be read BEFORE starting a job. The agency's SDS books are located in the upstairs Conference Room, Lab, Dental Clinic, and Environmental Health.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EXPOSURE CONTROL PLAN FOR NON-EMPLOYEES

DATE DEVELOPED: 11/99
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15

I. POLICY:

All non-employees with the Division of Public Health Services including contract staff and students will adhere to OSHA standards relating to blood, body fluids and respiratory disease.

II. PURPOSE:

To prevent transmission of bloodborne or respiratory infectious diseases.

III. GUIDELINES

A. All contract staff, students and other non-employees may receive training relating to OSHA and CDC standards for the prevention of bloodborne and/or respiratory transmitted infections.

1. Independent contract persons may receive training from agency staff.
2. Persons employed with a contracting agency will receive training from the vendor.
3. Students will receive the training from their educational institutions prior to being assigned to the agency; however students providing any direct care (i.e., pharmacy students) will be required to receive the Division of Public Health Services' OSHA Bloodborne Pathogen training within 10 days of start of rotation.
4. Proof of training may be submitted if training is received from somewhere other than the Division of Public Health Services.

B. All contract personnel, students and other non-employees are expected to comply with the OSHA standards and agency infection control policies and procedures while providing care to Division of Public Health Services' clients.

C. It is the responsibility of the independent contractor/vendor or educational institution to provide appropriate follow-up if exposure occurs to blood, body fluids or tuberculosis.

D. Each contract person, student, or other non-employee will receive the Hepatitis B vaccine and TB screening from his/her employer, educational institution or from a health care provider of his/her choice prior to contact with the agency's clients, or sign a waiver of declination.

E. All contract staff, students, and other non-employees will be provided Personal Protective Equipment (i.e., gloves, gowns, and masks, etc.) as appropriate for the care/services to be provided.

Contractors/Vendors will be responsible for providing Personal Protective Equipment for their employees.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SURVEILLANCE AND MONITORING SYSTEM

DATE DEVELOPED: 11/99
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Bloodborne Pathogens Surveillance and Monitoring System involves the safe performance of all jobs by the Division of Public Health Services.

II. PURPOSE:

To assure proper precautions and considerations are utilized and identify any opportunities for the agency to improve care.

III. GUIDELINES:

A. The Bloodborne Pathogens Surveillance and Monitoring System is an optional management tool that can be used to ensure employees' compliance with standard operating procedures. The components of the system include:

1. The requirement to communicate to all employees that they are responsible for performing their jobs according to standard operating procedures.
2. Ongoing management surveillance and supervisor/staff development coordinator quarterly observation and documentation of employee's work practices, and
3. Personnel policies that incorporate compliance with standard operating procedures into employees' performance evaluation(s) and provides for disciplinary action for noncompliance.

B. At a minimum, supervisors/staff development coordinator is to conduct formal workplace tours and document the results quarterly. Supervisors should exchange areas and "peer-audit" the work practices of other employee groups.

The surveillance and monitoring will be done to ensure compliance with safe work practices such as:

1. handwashing provisions and techniques,
2. disposal of contaminated needles and other sharps,
3. availability and use of protective clothing and equipment,

4. housekeeping, including cleaning, handling of contaminated laundry, decontamination, and labeling and disposing of regulated waste.

C. Monitoring will be done quarterly. The Staff Development Coordinator will maintain a Bloodborne Pathogens Surveillance and Monitoring Manual (or comparable computer program) that will contain:

1. the quarterly Bloodborne Pathogens Monitoring Form;
2. recommendations for corrective actions;
3. documentation of employee counseling, retraining, or education; and
4. a record of monitoring employees' work practices and employee disciplinary actions related to personal compliance on the Bloodborne Pathogens Monitoring Log.

D. Monitoring and its documentation on the Monitoring Log will include employees and procedures observed. Employees whose practices are satisfactory are to be noted for positive feedback and incorporation with personal job performance evaluations.

When monitoring reveals an employee's noncompliance with standard operating procedures, the need for procedural revision or update, or modification to the work environment or equipment, it will be documented on the Bloodborne Pathogens Monitoring Log. Recommendations for corrective action, such as personnel discipline, retraining, etc. or purchasing new equipment, will be recorded. The expected outcome of the recommendation and its date of completion will be noted.

Corrective action that involves employee work practice improvement(s) and any observed work practice improvement will be documented within two weeks. Continued employee noncompliance will be documented in permanent personnel records and disciplinary action instituted, according to Rockingham County personnel policies.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

BLOODBORNE PATHOGEN SURVEILLANCE AND MONITORING FORM

Date _____ Reviewer _____ Program Evaluated _____

No.	OBSERVED INFECTION CONTROL AND SAFETY MEASURES	Check Appropriate Box for demonstration or verbal response		
		YES	NO	NA
1.	Gloves worn when performing venipuncture and/or other vascular access procedures.			
2.	Gloves worn when handling blood and body fluids.			
3.	Gloves changed between clients.			
4.	Hand hygiene after gloves removed.			
5.	Hand hygiene before direct client care.			
6.	Face shield, masks, goggles, gloves, gowns are available and employee knows location.			
7.	Needles are NOT RECAPPED.			
8.	Needles, syringes, sharps are placed in puncture resistant, color-coded, leak-proof containers.			
9.	Appropriate handling and disposal of wound and skin dressings and waste products in Biohazard bags or trash receptacle.			
10.	Areas are properly cleaned following contamination with body fluids and between clients.			
11.	A new thermometer sheath is used with each client.			
12.	Vacutainer holder is disposed after each use.			
13.	Stethoscope bell and blood pressure cuff is cleaned with germicidal or alcohol wipes between clients.			
14.	Use sterile items that are not outdated.			
15.	Good body mechanics are used in lifting, turning and assisting in client care.			
16.	Provides information and instructions to clients and/or caregivers regarding infection control, maintenance of environment and equipment/safety.			
17.	Treatment rooms, counters, exam tables, blood pressure cuffs are cleaned weekly with approved solution and/or when contaminated.			
18.	Providing autoclave according to agency standards.			
19.	Are all areas that have been contaminated with blood or body fluids cleaned between clients?			
20.	Are staff cleaning all contaminated equipment according to standard precautions?			
21.	Are staff in specialized work environments complying with unique work practices (e.g. lab and dental clinic)?			

This evaluation is conducted as part of Improving Organizational Performance measures during the time of program audits.

Please identify incidents of non-compliance. State persons involved, date and complete all above and complete Monitoring Log. _____

_____

Report submitted to the Staff Development Coordinator or Infection Control Coordinator.

_____ _____
Name Date

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: STANDARD OPERATING PROCEDURE FOR THE EVALUATION OF SAFETY NEEDLES AND OTHER SHARP SAFETY DEVICES

DATE DEVELOPED: 3/19/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/24

I. POLICY:

The Division of Public Health Services provides a workplace and an environment as free as possible from recognized hazards that could cause injuries to our employees. The staff will use safety needle devices when delivering client care.

II. PURPOSE:

The Occupational Safety and Health Administration (OSHA) has revised the Bloodborne Pathogens standard in conformance with the requirements of the Needlestick Safety and Prevention Act. The Act was established to reduce the risk of transmission of bloodborne pathogens to medical personnel subjected to potential needlestick and sharps exposure. The Agency strives to promote and enhance a safe working environment and encourages employees to be aware of basic safety practices and to apply them to their daily work routines.

III. GUIDELINES:

A. A Safety Needle meeting **may consist** of the Director of Nursing, Clinical Supervisors, Staff Development Coordinator, Communicable Disease Program Coordinator, laboratory personnel, clinical staff, and immunization personnel may meet on an annual basis to review how sharps injuries occur, patterns of device use, and local and national data on injury and disease transmission trends and to consider and implement appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure. This is done in compliance with Federal, State, and OSHA requirements.

1. This meeting may occur annually and as needed. **It may also be incorporated into the department's routine safety meeting schedule.**
2. This meeting may review accident and injury reports as well as policies and procedures.

B. The Safety Needle meeting will be open to suggestions in the selection of safer devices by identifying various products now available on the market. Personnel will be given the opportunity to use various devices in the clinic

setting and evaluate them by means of the "Sharps Injury – Prevention Device Assessment Form."

C. The Safety Needle meeting will review accident and injury reports and make necessary changes regarding safety devices, procedures, and personnel as indicated. A Sharps Injury Log will be completed for each time an employee is injured with a contaminated sharp. The information gathered must include the following:

1. Department or work area where the incident occurred
2. Brand or type of device used
3. An explanation of how the incident occurred

Trends of unsafe practices will be identified and measures will be taken to provide assistance and training to prevent similar injuries from occurring in the future.

D. The Safety Needle meeting will perform periodic safety inspections to ensure that agency safety policies and procedures have been implemented correctly.

1. Assist in the evaluation and selection of safety devices.
2. Use of the safety devices that are provided throughout the Agency.
3. Do not recap needles.
4. Dispose of sharps devices in an appropriate sharps disposal container and only fill sharps to 2/3 full capacity.
5. Place the sharps container so that the employee has accurate visibility of the top of the container.
6. Report all needlesticks and other sharps related injuries promptly according to Exposure Policy.
7. Begin Bloodborne Pathogen training during orientation and annually, thereafter.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: INFECTION CONTROL STANDARD PRECAUTIONS

DATE DEVELOPED: 11/99
REVIEWED: 6/16; 6/17; 6/18; 10/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 10/18

I. POLICY:

The Division of Public Health Services' staff will follow standard precautions at all times when providing direct care to clients. The terms "universal precautions: and "standard precautions" are used throughout the Division of Public Health Services' Policies and Procedures interchangeably.

II. PURPOSE:

To treat all blood and body fluids as if they are infected for the purpose of reducing the incidence of infection by bloodborne pathogens.

III. GUIDELINES:

Bloodborne pathogens are major occupational health hazards in the health care industry. Engineering controls, work practice administrative controls, and personal protective equipment must be used to eliminate or minimize exposure to bloodborne pathogens or other potentially infectious materials.

A. Assume that blood and body fluids containing visible blood from all clients are potentially infectious.

B. HAND HYGIENE – Hand hygiene must be performed before and after patient contact, before and after using gloves, after contact with body secretions, when moving from a contaminated body site to a clean body site, and after contact with medical equipment in the vicinity of the patient. Alcohol-based hand rub (ABHR) may be used in most clinical situations per manufacturer's instructions. If hands are visibly soiled or after contact with a known or suspected case of any communicable disease, hand washing is the preferred method of hand hygiene. Steps for handwashing are detailed in policy IC-13.

C. GLOVES – such as vinyl, nitrile**,** or latex medical gloves must be worn when having direct contact with blood, body fluids, mucous membranes or non-intact skin, when handling items soiled with blood, or when handling equipment contaminated with blood or body fluids. Gloves should fit properly. This includes, but is not limited to the following:

1. Dressing changes
2. The handling of grossly contaminated clothing/articles
3. Emptying trash
4. Venipuncture or other vascular access procedures
5. Gloves must be worn when cleaning reusable equipment

Staff should wear gloves when "their" hands are abraded or irritated. Gloves should be changed after each client contact. When gloves are removed, hand hygiene is required. Gloves do not take the place of hand hygiene and should be changed between any procedure or treatment. Heavy utility gloves may be worn during routine decontamination cleaning procedures.

D. GOGGLES or PROTECTIVE GLASSES – should be worn when there is potential for a splash with blood or body fluids. Examples include: dental cleaning, venipuncture, and injections.

E. GOWNS or APRONS – A barrier-proof gown should be worn when there is a potential for blood or body fluid splatters or sprays.

F. MASKS – are usually not necessary if contact is only casual but should be worn if there is a chance of splash or splatters or the client is on respiratory precautions. Masks are worn only once and discarded; masks become ineffective when moist, usually after 20 minutes of use.

G. AIRWAYS – Although saliva has not been implicated in HIV transmission, a one-way airway, mouthpiece, resuscitation bag or other ventilation device should be available when resuscitation is predictable for use during actual resuscitation.

H. In the event of contamination with blood or body fluids, body surfaces should be washed immediately with soap and water.

I. All laboratory specimens should be treated as if they are contaminated with HCV, HIV, or HBV. All specimens should be clearly marked as such and transported in a well-constructed container with a secure lid with care taken to avoid contaminating the outside container. All procedures involving blood or other potentially infectious materials must be performed in such a manner to minimize splashing, spraying, splattering, and generation of droplets of these substances.

J. For disposal of contaminated supplies other than needles, <u>double-bagging</u> techniques should be used. Areas and equipment contaminated with blood should be cleaned as soon as possible with 1:10 bleach solution. Equipment can also be cleaned thoroughly and soaked in 70% isopropyl alcohol for ten minutes to inactivate HIV. Fresh bleach solution must be made daily and then discarded.

K. Soiled articles (e.g., lab coats) should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the articles. Articles soiled with blood or body fluids should be placed and transported in bags that prevent leakage.

L. Personnel cleaning biological spills or contaminated equipment should wear gloves and take care not to contaminate clothing. Disinfectant detergent formulas registered by the EPA can be used for cleaning environmental surfaces, but the actual physical removal of microorganisms by scrubbing is probably more important than any microbial effect of the cleaning agent used.

M. Staff members with exudative lesions or weeping dermatitis should refrain from all direct client care and from handling client care equipment until the condition resolves.

Disposal of Contaminated Items:

All contaminated items will be disposed of in a manner that will protect clients, caregivers and employees from exposure to microorganisms/viruses.

A. Always perform hand hygiene before and after contact with contaminated items and exercise extreme care to prevent accidental contamination or exposure to the contaminated items.

B. Gloves are always worn to handle contaminated dressings or supplies. Gowns or aprons should also be worn if there is a large spill or contamination. If the outside of a container becomes contaminated, employees must handle the container with gloves while placing the contaminated container inside a second leak-proof, biohazard-labeled container with a secure lid. Contaminated lab forms should be disposed of with regulated waste or autoclaved.

C. Place all contaminated items (dressing supplies) in a plastic bag. ALWAYS DOUBLE BAG CONTAMINATED ITEMS.

D. Remove gloves, place gloves in the bag and secure the bag.

E. Wash hands.

F. Place properly secured waste in the regular trash, double bagged.

G. Laundry should be considered contaminated and handled with gloves.

1. It is recommended that laundry be washed separately with detergent in water that is at least 160^0F for at least 25 minutes.

2. If the water is of a lower temperature, an appropriate disinfectant solution should be added, for example, bleach.

Disposal of Needles, Syringes and Sharp Items:

All needles, syringes and sharp items such as slides, lancets, and scalpels are disposed of in securely fastened rigid, puncture-proof, labeled containers. Care should be taken to protect clients, caregivers and provider employees from needlesticks or injury and exposure to microorganisms/viruses.

A. To prevent needlestick injuries, needles should never be recapped, bent, broken, or manipulated by hand. These items and other sharp items such as scalpels, razor blades, etc., should be considered potentially infectious and handled with extraordinary care. Used needles should be placed intact into puncture resistant containers. When the containers are 2/3 full, they are properly disposed of in accordance with arrangements made by the agency for disposal. Contractual services are used for Bio-Hazard Medical Waste Pick-up. Nurses return the sharps containers to the agency Bio-Hazard Medical Waste Box. It is recommended that the lids be taped securely.

B. Sharps Container in the Home

1. Clients/caregivers using needles for the self-administration of medications in the home should place the syringe with needle intact and the needle cap into a non-porous, non-penetrable container.

    a. Hard plastic containers are necessary since glass may break.
    b. A narrow neck to prevent items from being easily removed is preferred (i.e., bleach, Downey, Clorox or Minute Maid Orange Juice container).
    c. Container should remain in an upright position and be as close to the areas of use as possible.
    d. DO NOT REMOVE THE NEEDLE FROM THE SYRINGE OR REPLACE THE CAP ON THE NEEDLE.

2. The container should be sealed and disposed of when 2/3 full.

    - If leakage is possible, place the container in a secondary container that is closeable, leak-proof, and labeled.

3. Dispose of the container in the client's general trash after double bagging container.

4. Sharps – home containers should be disposed of within the home environment as stated above.

5. Broken glass that may be contaminated must not be picked up directly by hand. Clean with a dustpan and brush, tongs or forceps.

6. All metal or heat stable instruments must be sterilized by steam autoclave or chemical vapor. Metal speculums and other metal

instruments are not to be placed in the sink. Metal instruments are to be soaked in enzymatic cleaner according to agency's policy on use found in Section IC-15. The instruments should then be autoclaved as per the agency's policy on autoclaving in Section IC-15.

C. Sharps Containers Utilized by Staff

1. The staff will use an appropriately labeled biohazard non-porous, non-penetrable container for disposal of all sharps.

2. Staff will carry these sharps containers in an upright position separate from the "clean" area of the bag. During transportation, maintain container in a secured location, preferably the floor of the back seat.

3. The container should be sealed and disposed of when 2/3 full.

   - If leakage is possible, place the container in a second container that is closeable and leak-proof.

4. The 2/3 full sharps container will be brought back to the agency and disposed of in the Biohazard Container in the agency.

5. The Division of Public Health Services' Biohazard Containers will be disposed of via contractual services.

6. Cotton balls, alcohol swabs, and strips used with the reflotron are to be placed in counter top trash receptacles lined with plastic and transferred to an impervious bag at the end of the day.

Special Precautions:

DO NOT CUT, CLIP, BEND, BREAK, REMOVE OR RECAP NEEDLES.

DO NOT OVER-FILL SHARPS CONTAINERS.

ALWAYS PERFORM HAND HYGIENE BEFORE AND AFTER HANDLING SHARPS.

ISOLATION PRECAUTIONS:

Standard precautions with protective equipment constitute the most highly effective isolation precautions.

A. If possible, a separate room should be used for the person who is too ill to use good hygiene or has profuse diarrhea.

B. Masks should be worn when caring for clients when contact with respiratory droplet secretions is anticipated.

C. Families and caregivers are taught appropriate measures to protect themselves and the client from further disease transmission.

D. Respiratory precautions are instituted for suspected or confirmed infectious TB clients.

E. The diseases for which respiratory precautions are indicated are: TB (pulmonary or laryngeal), chickenpox, influenza and meningitis (until 24 hours after the start of therapy).

Medical Equipment:

A. Thermometers – use plastic sheath on all oral thermometers. If thermometer becomes soiled or contaminated, clean with 70% isopropyl alcohol prep pads.

B. Blood pressure cuff and stethoscope – if equipment becomes contaminated disassemble and clean with Cavi Wipes (disinfecting towelettes) according to manufacturer's instructions.

C. All employees are responsible for maintaining a clean and sanitary worksite at all times.

D. Additional work practices for laboratory personnel

1. Use plastic safety caps to remove the tops from vacuum tubes to prevent the aerosolizing of contents. Cover tops of vacuum tube with absorbent sponge, open away from employee.

2. Change gloves and perform hand hygiene after completion of specimen processing.

3. Mouth pipetting/suctioning is prohibited. Use mechanical devices for all pipetting.

4. During centrifugation, use a safety centrifuge cup or fiberglass shield to prevent aerosolizing of the contents.

5. All laboratory personnel must remove personal protective equipment (PPE) and wash their hands prior to leaving the laboratory.

6. Access to the laboratory is limited or restricted to laboratory personnel and housekeeping.

7. All equipment, work and environmental surfaces must be cleaned and decontaminated with Do It All Germicide Foaming Cleaner or an EPA approved disinfectant that is tuberculocidal and

antimicrobial with HIV efficacy claims, such as phenolic or quaternary ammonium germicidal detergent solution, once a day and after any spill of potentially infectious material.

a. Laboratory work surfaces should be impervious and easily cleanable.
b. Any material used to cover equipment and environmental surfaces must be removed and replaced as soon as possible when they become overtly contaminated or at the end of the work shift if they become contaminated during the shift.

8. Equipment that may become contaminated with blood or other potentially infectious material must be examined and decontaminated with Do It All Germicide Foaming Cleaner or an EPA approved disinfectant, such as phenolic or quaternary ammonium germicidal detergent solution, prior to servicing or shipping.

9. All specimens of blood or potentially infectious material are transported only in a well-constructed biohazard-labeled container with a secure lid to prevent leakage during collection, handling, processing, storage, transport or shipping. Contamination of the outside of the container and of the laboratory form should be avoided.

E. Additional Work Practices for Dental Health Personnel

1. A clinic smock or lab coat must be worn whenever clients are seen in the dental operatory for any procedures.

2. Eye protection must be used by all clinical staff during client treatment.

3. Face masks must be worn by all clinical staff during client treatment when spattering or aerosolizing of bloody or body fluids is likely. When wearing a mask is indicated, it must be changed when visibly soiled, contaminated, or wet.

4. Disposable gloves must be worn by clinical staff during all client contacts. All clinical staff must remove gloves and other protective equipment and wash their hands before leaving the operatory and after each client.

5. Operatory disinfection using Cavi Wipes (disinfecting towelettes) or any EPA approved disinfectant such as phenolic or quaternary ammonium germicidal detergent solution is required for environmental surfaces and equipment after each client visit.

F. Additional Work Practices for Offsite

1. The first line of defense is hand hygiene using the recommended techniques.

   a. Hand hygiene may be performed with an alcohol-based hand rub (ABHR) in most clinical situations. (Defer to handwashing when hands are visibly soiled or after contact with a known or suspected case of any communicable disease.) Steps for using an ABHR are as follows:

      (1) Follow manufacturer's instructions as to how much ABHR to dispense.
      (2) Cover all surfaces of the hands and fingers with ABHR.
      (3) Rub the ABHR on palms, back of hands, between fingers, around thumbs and under nails until all surfaces are dry.

   b. Handwashing is the preferred method when hands are visibly soiled or after contact with a known or suspected case of any communicable disease. Steps for handwashing are as follows:

      (1) Check that sink areas are supplied with soap and paper towels.
      (2) Turn on faucet and regulate water temperature (avoid using hot water because it may increase risk of dermatitis).
      (3) Wet hands and apply enough soap to cover all surfaces of hands.
      (4) Vigorously rub hands for at least 15 seconds including palms, back of hands, between fingers, under nails, and wrists.
      (5) Rinse thoroughly keeping fingertips pointed down.
      (6) Dry hands and wrists thoroughly with paper towels.
      (7) Use paper towel to turn off faucet to prevent contamination to clean hands.
      (8) Discard paper towel in waste receptacle.

2. Waste Disposal: Disposable items such as gloves, diapers, gowns, tissues, paper towels, etc., should be placed in a biohazard plastic bag and tied up.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SPILL KIT/SPILL PROCEDURE

DATE DEVELOPED: 7/03
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/24

I. POLICY:

Agency staff will use a spill kit to clean up any spills involving blood or body fluids.

II. PURPOSE:

To protect clients, caregivers and provider employees from injury and exposure to microorganisms/viruses. Blood and body fluid spills will be cleaned immediately. Visible material should be removed utilizing gloves and disposable cloths, and then the area decontaminated. With large spills of cultured or concentrated infectious agents, the contaminated area should be flooded before cleaning, and then decontaminated. Gloves should be worn during all cleaning and decontamination procedures, and gowns and eye protection should be worn if splattering is likely.

You may prefer to clean the surface with hot soapy water after any visible materials have been removed, then rinse the area and apply chlorine bleach diluted in water to the soiled area. (Dilute chlorine water 1:10 ratio.) Leave chlorine solution on the surface for at least 10 minutes. If necessary, remove excess chlorine with warm water.

A. Nursing Considerations:

1. Observe strict Standard Precautions.
2. Cleaning the contaminated area with bleach or alcohol will inactivate viruses.
3. Always double bag.
4. May double glove in large spills.
5. Report event to supervisor and document appropriately.
6. DO NOT use bleach on carpet or clothing.
7. DO NOT mix bleach with other cleaning agents.

B. Spill Kit Contains:

1. Gloves and apron
2. **Solidifying powder**
3. Red Disposal Bag with Closure

4. Scoop and Scraper to pick up solidified spill
5. Instructions – (See Below)
6. EPA Registered Disinfectant Wipes
7. Large Absorbent Wiper Towel
8. Antimicrobial Hand Cleaner

III. GUIDELINES:

A. Put on gloves.

B. Put on gown or apron and mask or goggles depending on the type and extent of the spill.

C. Completely cover the spill with the RED-Z Powder from the enclosed pouch. Within seconds the spill is solidified to a dry gel.

D. Once the spill is solidified, pick it up with the scoop and dispose of in white bag (or red bag) depending which kit is used.

E. Seal the bag tightly with the twist tie. (Do not seal if using Product No. 2038.)

F. Wipe the pre-cleaned area with the germicidal or chloride wipe. Dry the area with the absorbent towel. Clean away remaining solids and disinfect affected surface area with liquid disinfectant or the enclosed germicidal cloth.

G. Dispose all the material, including gloves, in the red plastic bag and secure with tie.

H. Discard red bag in second bag.

I. Wash hands thoroughly with soap and water or use antimicrobial hand cleaner.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: STERILE AND ASEPTIC TECHNIQUE

DATE DEVELOPED: 7/03
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services' staff will perform sterile and aseptic techniques competently.

II. PURPOSE:

To provide guidelines for using sterile and aseptic techniques.

III. GUIDELINES:

A. STERILE TECHNIQUE

1. Sterile items are totally free of germs or microorganisms and include such items as dressings, supplies, tubing, wound care and irrigation kits, etc.

2. Sterile items are always packaged to prevent contamination and will remain sterile as long as the package is not damaged or there is not a specific expiration date.

3. Prior to use of a sterile item:

   a. Inspect all packaging. DO NOT USE the item if the packaging is damaged or wet.
   b. Inspect all bottles or solution bags for signs of contamination. These include chips, tears, cracks, cloudiness, discoloration, or solid items floating inside (no matter how small).
   c. When opening the item, take extreme care to make sure the inside does not touch anything on the outside.
   d. Always wear sterile gloves to touch sterile items. DO NOT TOUCH ANY STERILE ITEM WITH YOUR HANDS.
   e. Always place sterile items on a sterile surface. This may include a separate sterile cloth/paper or the inside of the sterile package can be used as the sterile surface if it has not touched a non-sterile item.

B. ASEPTIC TECHNIQUE

1. The term aseptic means clean.

2. General guidelines to ensure an aseptic or clean environment or procedure:

   a. Clean the work area with an appropriate disinfecting or cleaning solution, preferably daily.
   b. Wipe the area with alcohol or a disinfectant solution prior to use.
   c. Cover the work area with a clean towel or cloth before beginning any work.
   d. Clean the area after the procedure.
   e. Wash hands before and after performing any procedure.
   f. Keep traffic in the area to a minimum, if possible.
   g. Avoid direct air currents on the area from open windows, doors, heat or air conditioning vents.
   h. Remember that anything around the clean work area is dirty including personal clothing.
   i. If you are not sure if an item is clean, throw it out or clean it prior to use.

3. Aseptic technique is adequate for most care given in the home.

C. CLIENT/CAREGIVER TEACHING RELATING TO STERILE AND ASEPTIC TECHNIQUE

1. Principles of disease transmission

2. Basic infection control measures, including handwashing, disposal of waste, care of equipment, disinfection, supply storage, and standard precautions

3. Use of the appropriate technique for the procedure

4. Signs and symptoms of infection

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NURSING BAG TECHNIQUE FOR HOME VISITING STAFF

DATE DEVELOPED: 7/03
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

All client care home visiting staff will use appropriate bag technique during home visits.

II. PURPOSE:

A. To allow nurses to safely carry equipment and supplies needed to provide care in clients' homes.

B. To keep contents of the bag as clean as possible.

III. GUIDELINES:

A. All contents of the inside section of the bag are considered clean. The outside of the bag is considered dirty.

B. Care should be taken to protect the client's furniture from marring with the bag or contents and from damaging surfaces by liquid spills.

C. Precautions should be taken to prevent transmission of contaminants on client care staff outer wear as well as equipment.

D. To insure the above guidelines follow the procedure as stated below:

1. Decide on needed equipment by review of the care plan and an assessment of the immediate situation in the home.

2. Select and prepare adequate work space from which to use the nursing bag.

   a. Location should be high enough for easy access and dry, but as close as possible to a water supply and still be convenient to the client.
   b. If there is a potential for the bag to become soiled, place bag on top of a protective barrier.

3. In preparing supplies for services:

    a. Remove paper or plastic bag to be used for waste receptacle and place nearby.
    b. Leave soap and towels by sink for washing hands after completing care.

4. Each time the bag is entered, the nurse must wash her hands or use antimicrobial hand cleaner.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: HAND HYGIENE

DATE DEVELOPED: 11/99
REVIEWED: 6/16; 6/17; 6/18; 10/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 10/18

I. POLICY:

Healthcare workers should perform hand hygiene when indicated as outlined in the guidelines and procedures below.

II. PURPOSE:

A. To remove organic material, transient microorganisms and dirt.

B. To prevent nosocomial infectious disease transmission between employees and clients.

C. To prevent cross-infection (spreading microorganisms from one person to another).

III. GUIDELINES:

A. Routine Hand Hygiene - For general client care, a plain, non-antimicrobial soap is recommended and/or alcohol-based hand rub (ABHR). Hand hygiene must be performed in the following situations:

1. when visibly soiled;
2. before and after client contact;
3. before and after touching wounds, non-intact skin, (whether surgical, traumatic, or associated with an invasive device);
4. before preparing medication or diagnostic agents;
5. before performing a procedure involving contact with a body orifice;
6. between client care procedures involving different body sites of the same client, for example from urinary to respiratory system;
7. before putting on gloves;
8. after contact with a source of microorganisms, body fluids, substances, mucous membranes, non-intact skin, and inanimate objects that are likely to be contaminated;
9. after removing gloves;
10. before handling food, eating or drinking liquids;
11. before the performance of invasive procedures;
12. when persistent antimicrobial activity on the hands is not desired

13. when it is important to reduce the number of resistant skin flora in addition to transient microorganisms; and
14. before care of newborns and severely immunocompromised clients, between clients in high-risk units, and when otherwise indicated during their care.

B. Hand hygiene may be performed with an alcohol-based hand rub (ABHR) in most clinical situations. (Defer to handwashing when hands are visibly soiled or after contact with a known or suspected case of any communicable disease.) Steps for using an ABHR are as follows:

1. Follow manufacturer's instructions as to how much ABHR to dispense.
2. Cover all surfaces of the hands and fingers with ABHR.
3. Rub the ABHR on palms, back of hands, between fingers, around thumbs and under nails until all surfaces are dry.

C. Handwashing is the preferred method when hands are visibly soiled or after contact with a known or suspected case of any communicable disease. Steps for handwashing are as follows:

1. Check that sink areas are supplied with soap and paper towels.
2. Turn on faucet and regulate water temperature (avoid using hot water because it may increase risk of dermatitis).
3. Wet hands and apply enough soap to cover all surfaces of hands.
4. Vigorously rub hands for at least 15 seconds including palms, back of hands, between fingers, under nails, and wrists.
5. Rinse thoroughly keeping fingertips pointed down.
6. Dry hands and wrists thoroughly with paper towels.
7. Use paper towel to turn off faucet to prevent contamination to clean hands.
8. Discard paper towel in waste receptacle.

D. <u>Important Points to Remember</u>:

1. Faucets are considered contaminated.
2. Inside of sink is considered contaminated.
3. If at any time during the washing procedure the hands touch the inside of the sink, the entire washing procedure should be repeated.
4. Chapped, rough skin is hard to keep clean and breaks down easily with washing.
5. Lotions

    a. Lotions may be used to prevent skin dryness associated with handwashing.
    b. If used, lotions should be supplied in small, individual use or pump dispenser containers that are not refilled.

c. Lotions selected for healthcare personnel should not contain petroleum or other oil emollients that may affect the integrity of gloves or the antimicrobial effects of the handwashing agent.

6. Conditions of the nails and hands

a. Nails should be short enough to allow the individual to thoroughly clean underneath them and not cause glove tears.
b. Skin on the hands/wrists is intact without open wounds or rashes.

7. Drying of hands

a. Cloth towels, hanging or roll type, are not recommended for use in health care facilities.
b. Paper towels or hand blowers should be within easy reach of the sink, but beyond splash contamination.
c. Lever operated towel dispensers should be activated before beginning handwashing. Hand blowers should be activated with the elbow.

E. Other Aspects of Hand Care and Protection:

Glove use following Standard Precautions:

a. Gloves should be used as an addition to, not a substitute for, hand hygiene.
b. Gloves should be used for hand-contaminating activities. Gloves should be removed and hand hygiene performed when such activity is completed, when the integrity of the gloves is in doubt, and between clients. Gloves may need to be changed during the care of a single client for example when moving from one procedure to another.
c. Disposable gloves should be used only once and should not be washed for reuse.
d. Gloves made of other materials should be available for personnel/ client with sensitivity to usual glove material (such as latex).

F. Hand Hygiene Competency Validation

1. Hand hygiene competency will be assessed for all direct-care providers:

a. Upon hire (during orientation);
b. Annually;
c. Routinely audited during “spot checks”.

2. Personnel will receive feedback on their hand hygiene performance by the validator after every audit performed.
3. For documentation, see Attachment 1 - Hand Hygiene Competency Validation.

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Hand Hygiene Competency Validation

Soap & Water

Alcohol Based Hand Rub (ABHR) (60% - 95% alcohol content)

Type of validation: Return demonstration	☐ Orientation ☐ Annual ☐ Other

Employee Name: _____ Job Title: _____

	Competent	
Hand Hygiene with Soap & Water	**YES**	**NO**
1. Checks that sink areas are supplied with soap and paper towels		
2. Turns on faucet and regulates water temperature		
3. Wets hands and applies enough soap to cover all surfaces of hands		
4. Vigorously rubs hands for at least ***15 seconds*** including palms, back of hands, between fingers, and wrists		
5. Rinses thoroughly keeping fingertips pointed down		
6. Dries hands and wrists thoroughly with paper towels		
7. Discards paper towel in wastebasket		
8. Uses paper towel to turn off faucet to prevent contamination to clean hands		
Hand Hygiene with ABHR		
9. Applies enough product to adequately cover all surfaces of hands		
10. Rubs hands including palms, back of hands, between fingers until all surfaces dry		
General Observations		
11. Direct care providers—no artificial nails or enhancements		
12. Natural nails are clean, well groomed, and tips less than ¼ inch long		
13. Skin is intact without open wounds or rashes		

Comments or follow up actions:

_____ _____/_____

Employee Signature Validator Signature Date

CDC at http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf NC SPICE; 9-2016 1

ATTACHMENT 1

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CARE OF IMMUNOCOMPROMISED CLIENTS

DATE DEVELOPED: 7/03
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services' staff will take precautions to reduce the risk of transmission of infectious disease to immuno-compromised clients.

II. PURPOSE:

To protect immuno-compromised clients from acquiring infection related to client care.

III. GUIDELINES:

A. Definition of Terms

1. The terms immunosuppressed and immunocompromised are often used interchangeably to describe individuals at high risk of developing infections due to alterations or disruptions in their host defense mechanisms.

2. Alterations or disruptions in host defense mechanisms may be due to clinical or underlying disease states, cancer, genetic abnormalities of the immune system, or diagnostic and therapeutic modalities.

3. Clients who are compromised are usually susceptible to infectious disease and easily develop disease due to organisms which normally do not cause disease in healthy individuals.

4. The normal microbial inhabitants of the skin, mucous membranes, GI, respiratory, and urinary systems may become opportunistic pathogens for immunocompromised clients.

B. Clients at high risk of being immunocompromised include those:

1. being treated with chemotherapy
2. being treated with immunosuppressing medications
3. having open wounds or burns
4. having HIV

C. To detect potential infections in the high-risk client population, staff should monitor several clinical parameters.

1. Fever pattern

2. White blood counts

   a. Clients are more susceptible to infection when they become neutropenic (decreased white blood counts).
   b. Neutropenia is the single most important predisposing factor for the development of infection in cancer clients.

3. Possible signs and symptoms of thrombocytopenia

   a. Platelet count less than 100,000
   b. Prolonged bleeding from a needle site or cut
   c. Blood in stool or rectum
   d. Easily bruised
   e. Development of petechiae

D. Prevention and Control of Infection

1. Practice meticulous handwashing with an antimicrobial handwashing agent before caring for the client.

2. Maintaining a clean environment and good personal hygiene will also decrease the microbial load and the likelihood of organism transmission.

3. Maintain intact skin and mucous membranes

   a. Avoid indwelling lines and catheters
   b. Avoid rectal temperatures and suppositories
   c. Prevent decubitus ulcers through passive and active exercises and massage to the skin and pressures areas
   d. Prevent dry skin with use of lotions, increased humidity, decreased baths and use of oil in bath water
   e. Prevent exposure to prolonged wet, soiled linen or moist soaks
   f. Provide good mouth care to maintain normal flora and prevent fungal or bacterial overgrowth
   g. Maintain good nutritional status.

4. Assessment and documentation of signs and symptoms

a. Staff should monitor the compromised client for the development of infection
b. Observations should be accurately described and recorded in the client's clinical record including:

- fever/fever patterns
- chills/chill patterns
- anorexia
- changes in pulse, respirations, blood pressure
- increasing or decreasing white blood counts
- pain
- lassitude, weakness, irritability, changes in mental status
- assess for specific infections

c. If client assessment indicates that an infection or potential infection exists, the following actions should be taken:

- Collect specimens prior to the initiation of antibiotic therapy, as ordered by the physician
- Monitor culture reports of agent sensitivity
- Monitor temperature and clinical signs/symptoms to determine host response
- Institute isolation precautions, if appropriate

5. Client and family education regarding the problems of the compromised host and appropriate care for these individuals, including:

a. Handwashing
b. Client hygiene
c. Importance of maintaining a clean environment
d. Provision of adequate nutrition and oral care
e. Maintain intact skin and mucous membranes
f. Signs and symptoms of infection to report and measures to take
g. Strict adherence to aseptic/sterile technique
h. Knowledge of diseases that may affect the client and appropriate care measures

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLEANING/CALIBRATION OF EQUIPMENT

DATE DEVELOPED: 7/03
REVIEWED: 6/17; 6/18; 10/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24; 7/24
REVISED: 6/15; 6/16; 10/18; 6/24; 7/24

I. POLICY:

All re-usable equipment will be cleaned when visibly soiled. All equipment that may require calibration will be assessed following the manufacturer's recommendation.

II. PURPOSE:

To ensure cleanliness of equipment and prevent the transmission of pathogens. Maintaining accuracy of equipment.

III. GUIDELINES:

A. HemoCue/**Glucometer**:

1. Each machine is thoroughly wiped down with an approved disinfectant towelette and air dried daily or as needed.
2. Alcohol is used to clean the machine.
3. Specific cleaning should follow manufacturer's recommendations.

B. Infant and/or Adult Scales:

1. Wipe with an approved disinfectant after each use if soiled or has come in contact with blood or body fluids.
2. No rinse is necessary.

C. Blood Pressure Cuff:

1. Cuffs that are visibly soiled are washed with soap and water or Cavicide disinfectant and allowed to dry thoroughly and/or cleaned with Cavicide weekly.
2. A paper towel or plastic wrap may be used between the client's arm and the cuff to reduce the risk of contamination.

D. Stethoscope:

1. The bell and diaphragm are wiped with alcohol after each use.
2. Allow to air dry before storing.
3. Cavicide solution may be used to clean stethoscope weekly.

E. Thermometer:

A disposable plastic sheath is used with digital thermometers and thermoscans when taking temperature and discarded after each use, taking care not to touch the outside of the sheath. **Wipe with alcohol and allow to air dry, if soiled or weekly.**

F. Otoscope:

1. Use disposable specula with each use.
2. Wipe with alcohol and allow to air dry, if soiled or weekly.

G. CPR Equipment: During CPR classes, an individual plastic covered mouthpiece may be used.

All Mannequins:

1. Clean with cavicide solution or wipes or germicidal wipes
2. Allow to air dry
3. If mannequin becomes contaminated clean with 1:10 bleach solution

H. Pulse Oximeter

1. Clean per manufacturer's recommendations.
2. Do not use alcohol on finger probe. The results may be "cracking" of pad and damage to light sensor.
3. May use moist towelette if necessary.

I. Nebulizer Machine

1. Wipe with Cavicide wipe after each use.
2 Agency uses disposable Nebulizer with T-Piece or mask mouthpiece, and tubing. Dispose of after use in biohazard bag.

J. Autoclaving

1. Wash instruments with Multi-Enzymatic Cleaner.
2. Rinse and dry.
3. Wrap instruments in wrapper.
4. Autoclave per agency Autoclave Policy (located Section IC-15-B).

K. Client Teaching of Household Cleaning:

1. Acceptable disinfectants should be used. Sponges or mops used to clean blood or body fluid spills should be rinsed and cleaned in the bathroom sink or tub, **not** the kitchen sink or where food is prepared. The tub or sink should be decontaminated with hot soapy water, rinsed and a chlorine bleach solution (dilute chlorine in water 1:10 ratio) applied for at least 10 minutes then rinse. Contaminated whirlpool water/solution should be disposed of in the toilet.
2. Common housekeeping procedures are usually adequate for cleaning environmental surfaces.
3. All food can be served on regular dinnerware. In general, contamination of dishes with a number of organisms large enough to induce infection is extremely unlikely. Eating utensils should be washed in hot soapy water or in a dishwasher.
4. Although soiled linen has been identified as a source of large numbers of pathogenic microorganisms, the risk of actual disease transmission is negligible. The use of protective apparel should be based on the likelihood of contact of exposed skin and/or clothing with soiled linen. Soiled linen should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen. The linen should be removed from the bed by rolling it to the center of the bed, and carried to the laundry hamper or washing machine by holding it away from clothing.

L. Equipment requiring calibration assessment:

1. Annual:

   a. Audiometers
   b. Sphygmomanometers
   c. Scales
   d. **Thermometers**

2. Other: Refrigerator thermometers may be replaced every two years or calibrated per manufacturer's recommendation.
3. Logs of equipment assessment/calibration are maintained in the Clinical Nursing Supervisor's office.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MULTI-ENZYMATIC CLEANER

DATE DEVELOPED: 10/18
REVIEWED: 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/19; 6/21

I. POLICY:

The Division of Public Health Services shall ensure all semi-critical items/ instruments shall be appropriately cleaned using Multi-Enzymatic Cleaner. Documentation of instrument cleaning should be recorded on the Instrument Cleaning Log. This log shall be kept in the Nurse's Work-up Room #24.

II. PURPOSE:

The purpose of this policy is to ensure that the Agency utilizes effective liquid solutions to clean equipment used in the clinical setting to prevent the spread or transmission of infections or communicable diseases.

III. EQUIPMENT/SUPPLIES:

A. Multi-Enzymatic Cleanser

B. Gloves (avoid neoprene or polyvinyl)

C. Protective eyewear

D. Impervious lab coat

E. Plastic container with lid

F. Instrument Cleaning Log

G. Tap Water

H. Plastic Medicine cup

I. Timer or watch

III. GUIDELINES:

A. The Instrument Cleaning Log shall be kept in the cabinet drawer located directly beneath the Autoclave.

B. The Instrument Cleaning Log shall be kept on file for a minimum of three years.

C. Staff working in the following program areas may use chemical disinfectants.

1. Family Planning
2. Adult Health
3. Child Health; and
4. Other staff, as deemed necessary

D. Semi-critical items/instruments that come into contact with intact mucous membranes and may or may not penetrate body surfaces such as speculums, irrigations syringes, scissors and other similar items may be cleaned.

1. Wear protective eyewear, gloves, impervious lab jacket (personal protective equipment or PPE) when cleaning or soaking equipment.
2. Clean equipment in a designated area (Storage Room #18).

E. Activation of Multi-Enzymatic Cleaner

1. Activate cleaner in a well-ventilated area according to manufacturer's instructions.
2. Place activated solution in a closed biohazard-labeled container. Label container as to contents, date of activation, and expiration dates as well as preparer's initials.
3. Prepare by placing ½ to 1 ounce of cleaner per gallon of water for general purpose cleaning.

F. Use of Enzymatic Cleaner:

1. Immerse instruments in prepared cleanser solution. Dissemble all instruments to ensure contact with the solution. Fully immerse all surfaces in the solution and soak for at least 2 minutes. Hard to remove matter may require increased soak times.
2. When soaking time is completed, items must be thoroughly rinsed in tap water to remove all traces of activated cleaner.
3. Maintain a log of all loads that includes the following information.

a. date
b. items cleaned
c. load number
d. time soaked in enzymatic cleaner
e. staff initials

4. Enzymatic cleaner may be discarded by flushing down the regular biohazard labeled drain with large quantities of water.
5. In the event of a small spill (<1 gallon) use the following procedure:

   Don personal protective equipment (gloves, lab jacket, and protective eyewear)

   a. use absorbent material to pick up all liquid
   b. seal absorbent paper and any other contaminated clothing in vapor-tight plastic bag(s) and place in a biohazard container
   c. wash any surfaces with soap and water

   An agency spill kit may also be used for any spill.

G. One time use of Enzymatic Cleaner:

   If the enzymatic cleaner is used infrequently, mix according to instructions, use and discard. Mixed solution is usable for 24 hours only.

H. Once instruments are cleaned and soaked, they are rinsed thoroughly, dried completely and prepared for ultraclave.

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ROCKINGHAM COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

INSTRUMENT CLEANING LOG FOR STERILIZER M11

Test Date:	**Time Soaked:**	**Load Results:**	**Comments/Instruments:**
		PASS	
Load No.:	**Initials:**	**FAIL**	
Test Date:	**Time Soaked:**	**Load Results:**	**Comments/Instruments:**
		PASS	
Load No.:	**Initials:**	**FAIL**	
Test Date:	**Time Soaked:**	**Load Results:**	**Comments/Instruments:**
		PASS	
Load No.:	**Initials:**	**FAIL**	

ROCKINGHAM COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

BIOLOGICAL INDICATOR LOG

Week of	Initials	Duration of Incubation	BI (sterilized in autoclave) (No color change = Pass)	Control BI (Color change = Pass)
		< 24 Hrs 24 Hrs >24 Hrs	PASS FAIL	PASS FAIL
		< 24 Hrs 24 Hrs >24 Hrs	PASS FAIL	PASS FAIL
		< 24 Hrs 24 Hrs >24 Hrs	PASS FAIL	PASS FAIL
		< 24 Hrs 24 Hrs >24 Hrs	PASS FAIL	PASS FAIL
		< 24 Hrs 24 Hrs >24 Hrs	PASS FAIL	PASS FAIL
		< 24 Hrs 24 Hrs >24 Hrs	PASS FAIL	PASS FAIL
		< 24 Hrs 24 Hrs >24 Hrs	PASS FAIL	PASS FAIL
		< 24 Hrs 24 Hrs >24 Hrs	PASS FAIL	PASS FAIL

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: OPERATION AND MAINTENANCE OF TUTTNAUER AUTOCLAVE

DATE DEVELOPED: 01/05
REVIEWED: 6/16; 6/17; 6/18; 10/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 10/18; 6/19; 6/21; 6/22

I. POLICY:

The Division of Public Health Services' clinic staff shall complete weekly and monthly maintenance of the autoclave to ensure proper functioning. Results shall be recorded in the Autoclave Maintenance Log. This log shall be kept on file for a minimum of three years.

II. PURPOSE:

The purpose of this policy is to assure that the maintenance and proper operation of the Autoclave is followed. This will ensure that medical equipment commonly used in the clinic setting will be sterilized properly to prevent the spread of communicable or infectious diseases.

III. GUIDELINES:

A. The Tuttnauer Autoclave maintenance log shall be kept in the cabinet drawer located directly beneath the autoclave.

B. Designated trained staff in the Division of Public Health Services will ensure that the Autoclave Maintenance Log is updated weekly and monthly as required by Agency Policy.

C. In order to detect potential sterilization failures, a weekly biological indicator (BI) test process will occur at the beginning of the workweek in the Tuttnauer Autoclave sterilizer at RCDPH.

1. Note the processing date on the biological indicator label.
2. Place BI inside of instrument tray or peel pouch.
3. Test most challenging area of the sterilizer (bottom of shelf near door or middle shelf). Process load as per manufacturer's instructions.
4. Retrieve the BI and confirm the chemical indicator printed on the label has turned brown. Wait 10 minutes prior to crushing. Wear protective eye wear when crushing.

5. Activate the processed BI by crushing the inner glass media tube using built in vial crusher. Place in dry block incubator.
6. Incubate at 131-140^0 for 24 hours checking spore growth (visual color change from purple to yellow) at regular intervals 3, 5, and 8 hours. Growth of surviving spores may only take as little as 2 ½ hours.
7. Record negative results in sterilizer record log as "PASS". No color change in the purple media after processing indicates proper sterilization.
8. Any positive result (growth indicated by purple to yellow color change) should be reported <u>immediately</u> and sterilizer taken out of service.

    a. Re-test by running another BI in a load without instruments.
    b. If BI is negative, the autoclave may be placed back into service.
    c. If BI is positive, keep the autoclave out of service and have it calibrated. Pull all loads ran up to the last negative BI. These items are considered unsterile and must be re-processed. Once autoclave is calibrated, it must run 3 consecutive loads all with a negative BI before it can be used again.

9. Use of BI control (the unprocessed BI) from same lot should be crushed and incubated each time the sterilizer is tested. Positive results are expected and recorded as "PASS". The use of the control verified BI is visible and indicates the incubator is working properly.
10. Storage and disposal of BI:

    a. Store between 60-80^0 F and 30-70^0 of relative humidity.
    b. Do not store near sterilants or other chemicals. Do not refrigerate.
    c. Do not use beyond stated shelf life on box.
    d. Negative (no growth) BI can be disposed of as normal waste, however, positive BI (growth) should be placed in the red sharps containers after use. RCDPH has all medical waste incinerated.

11. In loads that do not run a BI, a sterilization integrator strip must be used.

    a. The sterilization integrator strip should be placed in a challenging area of the sterilizer.
    b. The integrator measures time, temperature and steam penetration.

c. Check the integrator to see if the bar entered into the "SAFE" area. If the dark bar has <u>not</u> entered the "SAFE" area, <u>do not</u> release the load and report immediately. Record results in the sterilizer log.

12. All staff must review education CD-ROM prior to using biological indicators for the first time.

D. To use the Autoclave:

1. Press the ON button located on the side of the autoclave.
2. Refer to standard cycle parameters (copy is located in the drawer labeled Autoclave Supplies).
3. Select and press the appropriate sterilization program button and press start.

E. To maintain the Autoclave:

1. Follow the instructions as outlined in the Tuttnauer Operation and Maintenance Manual Book located on pages 95-107 that outlines the current maintenance instructions and will be followed by the agency.
2. The testing and Maintenance schedules are listed in the Tuttnauer Autoclave Log Book on pages 11-12 and will be followed by the agency.
3. Annual Maintenance logs are located on pages 14-30 in the Tuttnauer Autoclave Log Book on pages 11-12 and will be followed by the agency.

IV. <u>REFERENCES:</u>

Tuttnauer Table-Top Autoclave Log Book
Tuttnauer Operations and Maintenance Manual for Electronic Table-Top Autoclaves

(Both of these Manuals are kept directly below the autoclave in the drawer.)

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Cleaning of Semi-critical Items/Instruments Using Multi-Enzymatic Cleaner
Competency Skill Checklist

		Satisfactory	Non-Satisfactory	Initials
1.	Staff will wash hands or use antibacterial handwash prior to beginning procedure.			
2.	Dons the appropriate personal protective equipment which includes impervious lab coat, gloves, and protective eyewear.			
3.	Assembles equipment needed: Plastic medicine cups, timer/watch, covered container and label.			
4.	Pours enzymatic cleaner into container which is labeled with contents, date of activation, date of expiration, and initials. Use ½ to 1 ounce cleaner per one gallon of water. A minimum soak time of 2 minutes is recommended. Hard to remove matter may require additional soak times. Fresh cleanser should be made daily.			
5.	Thoroughly rinse enzymatic cleaner from instruments.			
6.	Once instruments have dried, sterilization may occur.			
7.	Be sure to record the following in the Instrument Cleaning Log: date, items disinfected, load number, time soaked, and initials.			
8.	When enzymatic cleaner is to be discarded, pour down sink in the Storage Room #18 and flush with large quantities of water.			

_____ successfully demonstrates the above criteria in the clinical setting.
(Employee)

_____ _____
Employee Signature and Date Reviewer's Initials and Date

_____ _____
Employee Signature and Date Reviewer's Initials and Date

_____ _____
Employee Signature and Date Reviewer's Initials and Date

Developed:
Reviewed: 6/15; 6/16; 6/17; 6/18; 10/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/15; 10/18

The program supervisor should store this information within the program. Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DONNING (APPLICATION) AND DOFFING (REMOVAL) OF PPE

DATE DEVELOPED: 3/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15

I. POLICY:

The Division of Public Health Services' staff members will implement the proper use of PPE for the care and screening of client with infectious or potentially contagious diseases or agents.

II. PURPOSE:

A. To control the spread of infection.

B. To protect individuals from the transmission of communicable or infectious diseases or agents.

III. GUIDELINES:

A. Staff should access the level of PPE warranted for the situation (standard, air borne, droplet) and don appropriate personal protective equipment (PPE) as set forth by the Employee Category of Risk Exposure to Blood and Body Fluids Policy (OSHA Manual section IC-2, page 3 and 4).

Recommended Personal Protective Equipment (PPE) includes the following single-use (disposable) items:

1. N-95 respirator
2. Hair cover
3. Full face shield
4. Impermeable gown (extends to mid-calf)
5. Nitrile exam gloves (two pairs with outer gloves having extended cuffs)
6. Fluid-resistant or impermeable shoe covers

B. Guidance from the Centers for Disease Control and Prevention (CDC) and the North Carolina Division of Public Health (NC DPH) published August 30, 2018 for donning (application) and doffing (removal) procedures shall be followed ensure safe and effective PPE use.

C. The CDC recommends double gloving to provide an extra layer of safety during direct patient care and during the PPE doffing process. *The CDC does not recommend adding additional layers of gloves because it may make it more*

difficult to perform patient care duties and put healthcare workers at greater risk for percutaneous injury (e.g., needle sticks) or self-contamination during doffing.

D. The following clinic areas are the designated donning and doffing locations:

1. Donning (application) the Nurses' Workroom
2. Patient evaluation/care/waiting for transport is Room 14
3. Doffing (removal) is Room 15

E. To ensure clinical staff is knowledgeable and proficient in the donning and doffing process, training on correct use of PPE shall be provided by the Communicable Disease Control Coordinator or a Trained Observer.

F. A Trained Observer will be utilized each time staff don or doff PPE and is necessary because the sequence and actions involved in each donning and doffing step are critical to avoiding exposure per CDC guidance.

1. The Trained Observer will read aloud to the healthcare worker each step in the procedure checklist (June 2020, see attached) and visually confirm and document that the step has been completed correctly.
2. The trained observer will provide immediate corrective instruction if the healthcare worker is not following the recommended steps.
3. The trained observer will notify the Clinical Supervisor or Director of Nursing in the event of an unintentional break in procedure or breech in PPE.
4. The trained observer ensures there is No exposed skin or hair at the conclusion of the donning process.
5. The Trained Observer (does not at any time enter the patient room).

G. During client care PPE must remain in place and be worn correctly for the duration of exposure to potentially contaminated areas.

1. PPE should not be modified or adjusted while in the exam room or during patient care.
2. No skin should be exposed while working in PPE.
3. Staff should perform frequent disinfection of gloved hands using an ABHR (alcohol based hand rub), especially after handling body fluids.
4. If during patient care a breach in PPE (e.g., gloves separate from sleeves leaving exposed skin, a tear develops in an outer glove, a needle stick) occurs, staff should disinfect the outer gloves and move immediately to the doffing area to assess the exposure.

H. PPE Doffing (removal) is a high-risk process that requires a structured procedure (checklist) and a designated area for PPE removal (Room 15) to ensure protection. The stepwise process should be used during training and daily practice.

1. PPE must be removed slowly and deliberately in the correct sequence to reduce the possibility of self-contamination.

2. The Trained Observer dons the following recommended disposable PPE (gown, face shield, gloves [2 pair], shoe covers) and waits in the doffing area (Room 15).

3. If the Trained Observer assists with doffing, they should disinfect their outer-gloved hands with ABHR immediately after contact with the healthcare worker's PPE.

IV. PROCEDURES:

A. Donning procedure (see donning checklist)

1. Remove all personal items
2. Pull hair up and away from face
3. Inspect PPE
4. Perform hand hygiene (bare hands)
5. Don inner gloves
6. Don gown
7. Don shoe covers
8. Perform hand hygiene (gloved hands)
9. Don appropriate size N95 respirator (located on the T drive in the Respiratory Protection folder)
10. Don hair cover
11. Don outer gloves
12. Don face shield (if indicated)
13. Inspect PPE (worker & trained observer)
14. Perform hand hygiene (gloved hands)

B. Doffing procedure (see doffing checklist)

While in exam room, the health care worker should disinfect outer gloves and inspect PPE. In doffing room (15), the trained observer should be donned in PPE and give the following doffing step instructions.

1. Disinfect outer gloves
2. Inspect PPE
3. Remove shoe covers
4. Doffing checklist item
5. Disinfect and remove outer gloves

6. Inspect inner gloves
7. Disinfect inner gloves
8. Remove face shield (if used)
9. Disinfect inner gloves
10. Remove hair cover
11. Disinfect inner gloves
12. Remove gown
13. Disinfect inner gloves
14. Remove N-95
15. Doffing checklist item
16. Disinfect inner gloves
17. Inspect & disinfect shoes
18. Disinfect inner gloves
19. Remove inner gloves
20. Perform hand hygiene bare hands
21. Inspect and notify the Clinical Supervisor or Director of Nursing in the event of an unintentional break in procedure or breech in PPE.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMPLOYEE (HEALTH CARE PERSONNEL) FOLLOW-UP FOR EXPOSURE TO BLOOD/BODY FLUIDS

DATE DEVELOPED: **11/99**
REVIEWED: **5/01; 7/03; 3/04; 2/05; 2/06; 3/07; 4/08; 3/09; 3/10; 6/10; 6/11; 6/12; 1/13; 6/13; 6/14; 1/24** ***(Archived 2014-2024 due to County policy)*****; 6/24**
REVISED: **3/04; 2/05; 2/06; 3/07; 1/13; 1/24**

I. POLICY:

The Division of Public Health Services will make a confidential medical evaluation available at no cost, for any incident involving a staff member's exposure to bloodborne pathogens.

II. PURPOSE:

To provide timely response and intervention in the event that an employee is exposed to bloodborne pathogens. **This service may be extended to other county agencies (EMS, Integrated Health, DSS, Sheriff's Department) as needed.**

III. GUIDELINES:

Health care personnel are defined as persons whose activities involve contact with clients or with blood or other body fluids from clients in a health care, laboratory, **dental,** or public safety setting.

A. All health care **or public safety** personnel sustaining exposure to:

1. body fluids or blood through needle stick, or to non-intact skin or mucous membranes
2. chemicals labeled as hazardous to skin, mucous membranes, or the respiratory system
3. communicable diseases for which immunity status has not been established, will initiate the completion of forms, blood work, counseling, and other follow-up as indicated, within 24 hours of the occurrence. Failure to complete all facets of the procedure outlines, to adhere to requirements and/or recommendations given during counseling, and/or repeated occurrences can result in termination.

B. Parenteral, mucous membrane and non-intact skin exposures to blood, tissues and other body fluids "containing visible blood" may result in transmission of bloodborne diseases such as Hepatitis B (HBV), Hepatitis C (HCV) or Human Immunodeficiency Virus (HIV). Percutaneous or non-intact skin exposures are cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids directly through the skin (e.g., puncture or

cut by contaminated sharp instruments or needles and introduction of blood or other body fluids, as defined above, onto mucous membranes (i.e., splashing into eyes or mouth). Any occupational exposure to feces, nasal secretions, breast milk, sputum, sweat, tears, urine, vomitus, or saliva not visibly contaminated with blood does not routinely constitute a risk of transmission of HBV, HCV, or HIV. Saliva, if injected through a human bite, may pose a risk of HBV transmission. Human bites that penetrate the skin should be managed as a potential exposure to HBV only.

**Note: Testing of the exposed employee and/or source person for Hepatitis B, Hepatitis C and/or HIV is always strongly recommended when a high risk of exposure and transmission has occurred. Regardless of the potential risk, any exposed employee has the right to request or decline testing.

Occupational Transmission of HBV

HBV has been demonstrated to survive in dried blood at room temperature environmental surfaces for at least 1 week. Thus, the potential for HBV transmission through contact with environmental surfaces has been demonstrated.

PEP for HBV

Efficacy of PEP for HBV: The effectiveness of hepatitis B immune globulin (HBIG) and/or hepatitis B vaccine in various postexposure settings has been evaluated by prospective studies. Regimens involving either multiple doses of HBIG alone or the hepatitis B vaccine series alone are 70%-75% effective in preventing HBV infection. In the occupational setting, multiple doses of HBIG initiated within 1 week following percutaneous exposure to HbsAg-positive blood provides an estimated 75% protection from HBV infection. In addition, because persons requiring PEP in the occupational setting are generally at continued risk for HBV exposure, they should receive the hepatitis B vaccine series.

Safety of PEP for HBV

Hepatitis B vaccines have been found to be safe when administered to infants, children, or adults. The most common side effects from hepatitis B vaccination are pain at the injection site and mild to moderate fever.

Serious adverse effects from HBIG when administered as recommended have been rare. Local pain and tenderness at the injection site, urticaria and angioedema might occur; anaphylactic reactions, although rare, have been reported following the injection of human immune globulin (IG) preparations. Persons with a history of anaphylactic reaction to IG should not receive HBIG.

PEP for HBV During Pregnancy

No apparent risk exists for adverse effects to developing fetuses when hepatitis B vaccine is administered to pregnant women (CDC, unpublished data, 1990). The vaccine contains noninfectious HbsAg particles and should pose no risk to the fetus. HBV infection during pregnancy might result in severe disease for the mother and chronic infection for the newborn. Therefore, neither pregnancy nor lactation should be considered a contraindication to vaccination of women. HBIG is not contraindicated for pregnant or lactating women.

Risk for Occupational Transmission of HCV

HCV is not transmitted efficiently through occupation exposures to blood. The average incidence of anti-HCV seroconversion after accidental percutaneous exposure from an

HCV-positive source is 1.8%. Transmission rarely occurs from mucous membrane exposures to blood, and no transmission in HCP has been documented from intact or non-intact skin exposures to blood. Data are limited on survival of HCV in the environment. The epidemiologic data for HCV suggest that environmental contamination with blood containing HCV is not a significant risk for transmission in the health-care setting, with the possible exception of the hemodialysis setting where HCV transmission related to environmental contamination and poor infection-control practices have been implicated. The risk for transmission from exposure to fluids or tissues other than HCV-infected blood also has not been quantified but is expected to be low.

No clinical trials have been conducted to assess postexposure use of antiviral agents to prevent HCV infection, and antivirals are not FDA-approved for this indication.

In the absence of PEP for HCV, recommendations for postexposure management are intended to achieve early identification of chronic disease and, if present, referred for evaluation of treatment options.

In the case of exposure to blood or other body fluids, the source should be assessed epidemiologically to determine the likelihood of human immunodeficiency virus (HIV) infection. Every effort should be made to test sources who are at high risk of HIV infection. In addition, blood should be collected from the exposed employee and either tested for HIV immediately or held until it is determined whether or not testing is indicated. The decision as to when to test the exposed employee's blood is left to the employee.

If the source is not at high risk for HIV infection, the decision to test or not is left up to the exposed employee. The recommended follow-up for potential exposure to HIV is based on whether or not the source blood is available for testing on these results. All test results must be kept confidential except to report positive results through the health department and/or the Centers for Disease Control (CDC).

C. The Division of Public Health Services will adhere to the following measures through the counseling and follow-up procedures under the guidance of the communicable disease coordinator, supervisor, or director of clinical services.

SOURCE KNOWN: HIV NEGATIVE

1. Determine whether or not the source is at high risk for infection with HIV.

    a. If at high risk, the source will be retested at 12 weeks after the exposure incident (to determine whether the source was in the "window phase" at the time of the first test).
    b. The exposed person should be advised to report and seek medical evaluation for any acute febrile illness occurring within 12 weeks after exposure. Such an illness, particularly if characterized by fever, rash or lymphadenopathy, may be indicative of recent HIV infection.
    c. During this time, the exposed person should receive and follow the USPHS recommendations for preventing transmission of HIV.
    d. If the results of the source's 12-week retest are negative, no testing of the exposed person or source is indicated.
    e. If the results of the source's 12-week retest are positive, the original serum of the exposed person will be tested and the exposed person immediately retested.
    f. If the exposed person's 12-week test is negative, he/she will be retested at six months post-exposure.
    g. If the exposed person's 12-week test is negative at six months post-exposure, no further follow-up is indicated.
    h. If an HIV-negative source is not at high risk, no subsequent testing of the source or the exposed person is indicated.

SOURCE KNOWN: HIV POSITIVE

1. The exposed person should immediately be referred through the Division of Public Health Services to a physician.

2. The blood of the exposed person should be tested for HIV antibody immediately.

a. If negative, retest at six weeks, 12 weeks, and six months after exposure.
b. If positive at any time, the exposed person will be referred to a physician for clinical follow-up, and to a designated AIDS counselor for counseling. No further HIV testing is indicated. HIV-Positive persons should follow the USPHS recommendations for preventing transmission of HIV.

3. The exposed person should be advised to report and seek medical evaluation for any acute febrile illness occurring within 12 weeks after exposure. Such an illness, particularly if characterized by fever, rash or lymphadenopathy, may be indicative of recent HIV infection.

4. During the first 12 weeks after exposure (the time during which most infected persons seroconvert), the exposed person should follow USPHS recommendations for preventing transmission of HIV.

5. Counseling and Education. Although HIV infection following an occupational exposure occurs infrequently, the emotional effect of an exposure often is substantial. In addition, HCP are given seemingly conflicting information. Although HCP are told that a low risk exists for HIV transmission, a 4-week regimen of PEP might be recommended, and they are asked to commit to behavioral measures (e.g., sexual abstinence or condom use) to prevent secondary transmission, all of which influence their lives for several weeks to months. Therefore, access to persons who are knowledgeable about occupational HIV transmission and who can deal with the many concerns an HIV exposure might generate for the exposed person is an important element of postexposure management. HIV-exposed HCP should be advised to use the following measures to prevent secondary transmission during the follow-up period, especially the first 6-12 weeks after the exposure when most HIV-infected persons are expected to seroconvert:
   - exercise sexual abstinence or use condoms to prevent sexual transmission and to
   - avoid pregnancy; and
   - refrain from donating blood, plasma, organs, tissue, or semen.
   - If an exposed woman is breast feeding, she should be counseled about the risk of HIV transmission through breast milk, and discontinuation of breast feeding should be considered, especially for high-risk exposures. Additionally, NRTIs are known to pass into breast milk, as is NVP;

whether this also is true for the other approved antiretroviral drugs is unknown.

SOURCE UNKNOWN

1. Determine whether the exposure occurred in a setting where the likelihood of seeing an HIV-infected person was high. If so, management will be in accordance with HIV-positive status.

2. If the likelihood of exposure to HIV-infected blood is unknown or low risk, the decision to test for HIV is left up to the exposed person. Testing is available to any exposed person who is concerned about the exposure to HIV. If testing is chosen in this situation, follow management as indicated in HIV-positive status.

WHEN EXPOSURE OCCURS

When an inadvertent percutaneous or permucosal exposure to blood or other potentially infectious material occurs:

Employees are required to:

1. Remove contaminated personal protective equipment and place it in a red or biohazard labeled bag.

2. Wash exposed areas (hands and other skin surfaces) with soap and water. Immediately flush exposed mucous membranes with water, and, if exposed, flush eyes with large amounts of water or eye wash solution for 15 minutes. May use eye wash located in the lab.

3. Immediately report exposure to the supervisor. The supervisor is to immediately report incident to the Safety and Risk Manager (342-8265 or **588-5302**). If the exposure occurs after 5:00 p.m. or on weekend or holiday, the employee should notify the supervisor – if unable to locate, then call the Director of Nursing and seek medical attention as directed. The employee may be directed to go to **local hospital emergency room. If not, public health employee have supervisor contact DON (336-951-7549), Clinical Supervisor (336-932-3673), or CD Nurse (336-342-8163/336-589-5715).** The written reports from the employee and supervisor must be completed and sent to the County Risk Manager on the same day of incident **or as soon as possible**.

4. If there is a spill, decontaminate the spill area with an EPA-approved disinfectant, such as phenolic of quaternary ammonium germicidal detergent solution or a 1:10 to a 1:100 dilution of bleach. Spill kits are provided for use by staff.

5. Seek medical care if first aid is needed or if signs of infection, such as redness or swelling occur.

6. Complete a report of exposure within 24 hours or within the first regular working day after the event of the exposure providing as many details as possible about the exposure.

   RECOMMENDATIONS FOR THE CONTENTS OF THE OCCUPATIONAL EXPOSURE REPORT
   - date and time of exposure;
   - details of the procedure being performed, including where and how the exposure occurred; if related to a sharp device, the type and brand of device and how and when in the course of handling the device the exposure occurred;
   - details of the exposure, including the type and amount of fluid or material and the severity of the exposure (e.g., for a percutaneous exposure, depth of injury and whether fluid was injected; for a skin or mucous membrane exposure, the estimated volume of material and the condition of the skin [e.g., chapped, abraded, intact]);
   - details about the exposure source (e.g., whether the source material contained HBV, HCV, or HIV; if the source is HIV-infected, the stage of disease, history of antiretroviral therapy, viral load, and antiretroviral resistance information, if known);
   - details about the exposed person (e.g., hepatitis B vaccination and vaccine-response status);
   - details about counseling, postexposure management, and follow-up; and
   - an explanation of the signs and labels and/or color coding.

7. If employee is unable to decontaminate while in the client's home:

   a. Cover self with impervious gown.
   b. Cover vehicle-seating area, if necessary with any plastic covering available for use.
   c. **IMMEDIATELY:** Return home to remove soiled clothing and launder as soon as possible. Launder soiled clothes alone to prevent cross-contamination.
   d. Shower as soon as possible after removal of soiled clothing. Use antibacterial soap, or other agents as MSDS guidelines specify.
   e. Report event to agency.

   The Supervisor is required to:

   a. Assist the employee to complete the exposure report and

sharps injury log as necessary. Be sure the report documents both the area exposed and the circumstances under which the exposure occurred.

b. Review the procedures involved in the exposure and methods to prevent future exposures with the employee.

c. Obtain the name, address, phone number, and HIV/HBV status of the source client.

The **Director of Nursing (DON)/Clinical Supervisor**/ Communicable Disease Coordinator is required to:

a. If possible, arrange to collect a blood sample from the source client. Notify the attending physician that an exposure has occurred and ask that he notify the health professional providing follow-up care of the HBV, HCV and HIV status of the source, if known, or approve testing of the source individual on the day of the event. Obtain release of information from client.

b. Arrange a medical follow-up for the exposed employee as soon as possible after the exposure. This follow-up should include:
   (1) Counseling regarding risk of infection.
   (2) Medical evaluation of any febrile illness that occurs within twelve weeks post-exposure.
   (3) Post-exposure treatment and prophylaxis.
      - If indicated, start PEP as soon as possible after an exposure.
      - Reevaluation of the exposed person should be considered within 72 hours postexposure, especially as additional information about the exposure or source person becomes available.
      - Administer PEP for 4 weeks, if tolerated.
      - If a source person is determined to be HIV-negative, PEP should be discontinued.

c. Instruct the employee regarding confidentiality of the source person.

d. Information will be compiled and forwarded to Safety/Risk Management for recording in the OSHA 300 Log.

The Health Care Provider (Supervisor/Communicable Disease Coordinator/**DON**) responsibilities include:

a. Review the status of the employee's hepatitis B vaccination and response, if available.

b. Conduct HIV and HBV, HCV pre-test counseling with the exposed employee prior to receiving the result of the source person's laboratory tests.

c. Obtain consent for a confidential baseline blood sample to determine the employee's HBV, HCV and HIV status within hours of exposure rather than days. If the employee consents to a baseline blood specimen collection, but does not give consent for serological testing, the physician will be notified and documentation will be made in the agency employee medical record, and the serum sample must be stored by freezing at -20ºC, for 90 days (if stored longer, must be frozen at -70ºC). If within 90 days of exposure, the employee elects to have the baseline sample tested, testing will be done as soon as possible.

d. Provide post-exposure counseling upon return of the laboratory results and initiate post-exposure management and treatment in accordance with communicable disease rules.

e. Make arrangements for HIV and HbsAg testing and counseling of source person, if known, according to the communicable disease rules [**10A NCAC 41A.203 and G5 15A-534.3**], unless already known to be infected.

f. The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV, HCV and HIV infectivity. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

(1) When the source individual is already known to be infected with HBV, HCV or HIV, testing for the source individual's known HBV, HCV or HIV status need not be repeated.

(2) Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

g. Follow the Hepatitis B prophylaxis after percutaneous and permucosal exposure, as required by the communicable disease rule and HBV-Manual. Submit a written notification of the counseling to the employee and the employee's supervisor within 15 days of completion of the evaluation.

(1) Postexposure Testing. HCP with occupational exposure to HIV should receive follow-up counseling, postexposure testing, and medical evaluation, and evaluation of reported illnesses,

regardless of whether they receive PEP. HIV-antibody testing should be performed for at least months postexposure (e.g., at 6 weeks, 12 weeks, and 6 months).

(2) The results of the source client's testing shall be made available to the exposed employee.

(3) Within 15 days after the evaluation is completed, the employer must obtain and provide the employee with a copy of the healthcare professional's written opinion. It must include the following:

- For the Hepatitis B Vaccination, the opinion is limited to whether the employee required or has received the Hepatitis B Vaccination.
- For the post-exposure evaluation and follow-up, the opinion shall be limited to:
  - Information that the employee has been informed of the results of the evaluation.
  - Information that the employee has been told about any medical conditions that require further treatment.

(4) All other findings or diagnosis shall remain confidential and shall "**not**" be included in the written report. Access to this information should be limited to a legitimate business need and not to discriminate against the employee.

OSHA's confidentiality rules: Properly recording the information on an exposure incident is confidential but the incident, including the employee's name, is recorded in the OSHA 200 Log if conversion occurs.

h. All laboratory analysis and medical follow-up is provided to the employee at no cost.

i. The agency will maintain a confidential medical record for each exposed employee for the duration of employment plus thirty years. The record will include:

(1) Employee's name and social security number.

(2) Copy of the employee's Hepatitis B vaccination status including the dates of all vaccinations.

(3) Any medical records relative to the employee's ability to receive the vaccine.

(4) A copy of all results of examinations, medical testing, and follow-up procedures.

(5) The employer's copy of the health professional's written opinion.

(6) A copy of the information provided to the health care professional.

j. All employee medical records must be kept confidential and not disclosed or reported without the employee's express written consent to any person except as required by law.

D. Chemical Exposure:

1. Refer immediately to Material Safety Data Sheet (MSDS) or Poison Control Center for immediate treatment and implementation. The Poison Control Center telephone number is 1-800-222-1222.
2. Report exposure to Communicable Disease Program Coordinator.
3. Complete Accident/Incident Form (see appendices).
4. Complete OSHA Form 200 as directed by Communicable Disease Program Coordinator.
5. The employee receives counseling and in-service on the use of appropriate personal protective equipment.
6. Depending on situation, first exposure may be enough for discipline.

E. PROCEDURE:

Communicable Diseases:

1. Report exposure to Communicable Disease Program Coordinator.
2. Complete the Accident/Incident Form.
3. **OSHA Form 200 will be completed by the Safety Risk Manager.**
4. If indicated through history and documentation, the employee may have titer levels drawn and treatment may be administered as a booster or medications by further advice by physician/Advanced Practice Provider (APP).
5. The physician/Advanced Practice Provider (APP) may decide if employee is able to return to direct client contact duties.

If medical treatment is administered to the exposed employee (e.g. HBIG or a booster hepatitis B immunization is given), record the exposure incident as an injury, not an illness.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

PROCEDURE FOR NEEDLE STICK OR EXPOSURE TO BLOODBORNE PATHOGEN

Exposure Occurs
↓
Wash Exposed Area
Remove & Secure Contaminated Articles
↓
Complete – Report of Exposure Form with Supervisor
Obtain consent for baseline testing
Send confidential report to Communicable Disease Nurse/Infection Control Coordinator
↓
Communicable Disease Nurse/Infection Control Coordinator will evaluate report

If event is BB Exposure ↓

- Begin employee Pre-Test counseling
- Obtain consent for baseline testing
- Offer prophylaxis therapy ASAP via hospital or private physician
- Detail follow-up dates for additional employee testing if indicated
- Obtain employee Hepatitis B & HIV status

Within 15 days provide post exposure written opinion & post test counseling to employee and file in employee's medical record.

- Document on Report of Exposure Annual Summary

Needlestick ↓

- Begin employee Pre-Test counseling
- Obtain consent for baseline testing
- Offer prophylaxis therapy ASAP via hospital or private physician
- Detail follow-up dates for additional employee testing if indicated
- Obtain employee Hepatitis B & HIV status

Within 15 days provide post exposure written opinion & post test counseling to employee and file in employee's medical record.

- Complete Sharps Investigation Notification
- Complete Needlestick and Sharp Injury Report Form
- Send copy of Needlestick and Sharp Injury Report Form to agency personnel
- Document on Report of Exposure Annual Summary Form

QUICK CHECK REFERENCE FOR MANAGEMENT OF OCCUPATIONAL BLOOD EXPOSURES

Provide immediate care to the exposure site.

- Wash wounds and skin with soap and water
- Flush mucous membranes with water.

Determine risk associated with exposure by

- type of fluid (e.g., blood, visibly bloody fluid, other potentially infectious fluid or tissue, and concentrated virus) and
- type of exposure (i.e., percutaneous injury, mucous membrane or nonintact skin exposure, and bites resulting in blood exposure).

Evaluate exposure source.

- Assess the risk of infection using available information.
- Test known sources for HbsAg, anti-HCV, and HIV antibody (consider using rapid testing).
- For unknown sources, assess risk of exposure to HBV, HCV, or HIV infection.
- Do not test discarded needles or syringes for virus contamination.

Evaluate the exposed person.

- Assess immune status for HBV infection (i.e., by history of hepatitis B vaccine and vaccine response).

Give PEP for exposures posing risk of infection transmission. Refer to physician or emergency room.

- HBV
- HCV:PEP not recommended.
- HIV
    - Initiate PEP as soon as possible, preferably within hours of exposure.
    - Offer pregnancy testing to all women of childbearing age not known to be pregnant.
    - Seek expert consultation if viral resistance is suspected.
    - Administer PEP for 4 weeks if tolerated.

Perform follow-up testing and provide counseling.

- Advise exposed persons to seek medical evaluation for any acute illness occurring during follow-up.

QUICK CHECK REFERENCE FOR
MANAGEMENT OF OCCUPATIONAL BLOOD EXPOSURES
PAGE 2

HBV exposures

- Perform follow-up anti-HBs testing in persons who receive hepatitis B vaccine.
  - Test for anti-HBs 1-2 months after last dose of vaccine.
  - Anti-HBs response to vaccine cannot be ascertained if HBIG was received in the previous 3-4 months.

HCV exposures

- Perform baseline and follow-up for anti-HCV and alanine amino-transferase (ALT) 4-6 months after exposures.
- Perform HCV RNA at 4-6 weeks if earlier diagnosis of HCV infection desired.
- Confirm repeatedly reactive anti-HCV enzyme immunoassays (EIAs) with supplemental tests.

HIV exposures

- Perform HIV-antibody testing for at least 6 months postexposure (e.g., at baseline, 6 weeks, 3 months, and 6 months).
- Perform HIV antibody testing if illness compatible with an acute retroviral syndrome occurs.
- Advise exposed persons to use precautions to prevent secondary transmission during the follow-up period.
- Evaluate exposed persons taking PEP within 72 hours after exposure and monitor for drug toxicity for at least 2 weeks.

ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

REPORT OF EXPOSURE

Employee: _____ Job Title: _____

Program: _____

Date of Exposure: _____ Time of Exposure: _____am/pm

Type of Exposure; Via what route? Needle stick ____ Body Fluid Drainage ____
Broken Glass ____ Secretions ____ Mucous Membranes ____ Skin Chapped ____
Abraided ____ Intact ____

Describe how the incident occurred (include activity taking place): _____
_____
_____

Review the explanation of signs and labels and/or color coding: _____
_____

Conditions of Exposure (location, confined space, clinic, client home, community health fair):
_____
_____

List the name & type of personal protective equipment used at time of exposure:
Lab Coat ____ Gloves ____ Impervious Gown ____ Safety Needle Devices: ____
Mask ____ Face Shield/Goggles ____

Detailed explanation if protective equipment was not being used or PPE failed:
_____

SOURCE INFORMATION:

Name: _____ MR Number: _____

Address: _____ Telephone Number: _____

Whether source material is known to be contagious: HBV ____ HCV ____ HIV ____

If HIV infected: Stage of disease _____

Antiretroviral History of Therapy _____

Names of other potentially exposed people involved in this incident:

Name: _____ Home Telephone: _____

Name: _____ Home Telephone: _____

Notify source's physician that exposure has occurred and ask them to provide follow-up as needed for care of HBV, HCV, or HIV if identified from source's blood.
Blood drawn from source and date: _____

Preliminary instructions to the employee: _____
_____
_____

FOLLOW-UP PROTOCOL:

Medical Follow-up: Health care provider will review status of employee's Hepatitis B vaccination and response. List dates of vaccines and date waiver was signed: _____
_____

List Health care provider that conducted HIV, HCV, and HBV pre-test counseling and instructions given prior to the result of lab test: _____
_____

Offer Medication Follow-up if exposure is reported as soon as possible through hospital or private provider: _____

Obtain consent for a confidential baseline blood sample to determine employee's HBV, HCV, and HIV status. I _____ on date _____
consent/do not consent to a baseline blood sampling to determine HBV, HCV, & HIV status.

POST-EXPOSURE COUNSELING – LAB RESULTS RETURNED

Provide post-exposure counseling upon return of lab results and initiate post exposure management and treatment. Follow-up dates and testing conducted: I understand these are my dates for follow-up testing. It is my responsibility to contact the supervisor to schedule these follow-up appointment dates.

I _____ on date _____
consent/do not consent for any follow-up care regarding this exposure.

6 weeks _____

12 weeks _____

6 months _____

1 year _____

I have received counseling regarding the importance of post exposure follow-up. I relinquish any responsibility of the Division of Public Health Services to my decision as stated.

Signature of Employee _____ Date _____
Counselor _____ Date _____

The information contained above is confidential information.

ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

EMPLOYEE CONSENT FOR VENIPUNCTURE
TO OBTAIN BASELINE STATUS

My Physician or Health Care Provider _____ was notified on _____, that I, a Division of Public Health Services' employee, was exposed to blood, body fluid, or secretion while performing a procedure. I ***consent / do not consent*** to having my blood drawn in order to test for the status of Hepatitis B, HCV, and HIV.

_____ _____
Employee's Signature Date

_____ _____
Signature of Witness Date

THE INFORMATION CONTAINED ABOVE IS CONFIDENTIAL INFORMATION. THE DIVISION OF PUBLIC HEALTH SERVICES DOES ACKNOWLEDGE THIS INFORMATION TO BE CONFIDENTIAL.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

LABORATORY POLICIES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SCOPE OF LABORATORY SERVICES

DATE DEVELOPED:
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 10/22; 6/23; 11/23; 6/24
REVISED: 2/16; 6/16; 6/16; 6/17; 6/18; 6/20; 6/21; 10/22; 11/23; 6/24

I. MISSION:

The laboratory of the Division of Public Health, located in Wentworth, NC, provides medical laboratory testing in support of the clinics' health programs. All functions of the laboratory are regulated by the Clinical Laboratory Improvement Amendments of 1993, which set federal standards designed to improve the quality of clinical laboratory services.

II. PURPOSE:

The purpose of the Laboratory Manual is to set forth the general, personnel and procedural policies of the Rockingham County Department of Health and Human Services (RCDHHS) laboratory. A copy of this manual will be kept in the laboratory. This manual is reviewed and approved annually. It is updated to reflect current practices. All laboratory personnel are oriented to the manual upon employment and required to review its contents annually.

III. ORGANIZATION:

A. All functions of this laboratory facility are regulated by the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) and are to be authorized by the laboratory manager and lab consultant.

B. RCDHHS laboratory is classified as "moderate" and operates under the umbrella CLIA certificate of Area B of the North Carolina State Laboratory of Public Health in Raleigh, North Carolina.

C. The current RCDHHS Medical Director serves as the Clinical Consultant and **Tracey Shives, MLS (ASCP)** serves as the Laboratory Director.

D. Technical consultation is provided through the Technical Consultant, Tracey Shives, MT (ASCP). The Technical Consultant provides assistance with the laboratory policy and procedure manuals, laboratory QA and safety, and other laboratory functions.

E. On-site laboratory supervision and administration is provided by the Nursing Section Supervisor who serves as the Laboratory Manager's supervisor.

F. Laboratory testing is primarily performed by one fulltime laboratory technician/technologist who functions as the laboratory manager. There is also one fulltime medical office assistant that routinely performs laboratory duties. Laboratory testing is also performed by qualified nursing staff.

G. Staff members are assigned laboratory responsibilities by the Nursing Supervisor. During temporary absences of the laboratory technician, the Nursing Supervisor assigns laboratory duties to other qualified staff members, who are approved testing personnel. All laboratory testing personnel must be approved by the Laboratory Director and Laboratory Manager.

H. Laboratory budgetary needs are primarily determined by the laboratory technician and the Nursing Supervisor. Requests and justifications are submitted to the Health Director through the Nursing Director.

I. The Division of Public Health is located in the County Governmental Building located on Highway 65 West, Reidsville, N.C. The mailing address is:

Rockingham County Department of Health and Human Services
Post Office Box 204
Wentworth, NC 27375

1. The department routinely operates Monday through Friday, 8:00 a.m. - 5:00 p.m., except during scheduled holidays and/or weekends and night clinics.

2. The lab manager or lab technician will come in at 8:00 a.m. daily to send labs to the ordering providers. The lab manager or lab technician will provide lab coverage for extended clinical hours on Thursday afternoons until night clinical duties are completed. The overtime is compensated the next day if possible and if applicable to agency needs.

3. Cultures may need to be read over the weekend or scheduled holidays. The lab manager and lab technician rotate weekend coverage to provide this service.

4. The RCDHHS is listed under the North Carolina Health Department Area B CLIA certificate #34D0865330.

J. Standing Orders:

1. Standing orders for laboratory testing are specified in program protocols which are approved and signed by the Medical Director who serves as the Laboratory Clinical Consultant.

2. Protocols with standing orders are found in program manuals located in the Nursing Supervisor's office and on the Department's "H" drive.

3. All laboratory tests requested by standing orders are listed on the Laboratory Requisition Form.

K. Testing -

The following tests are performed in the laboratory:

Moderately Complex Tests	Waived Tests
GC Culture	Glucose
Gram Stain	Urine Pregnancy Test
Stat Male Urethral Smear	Hemoglobin
Urine Microscopy	Fecal Occult Blood
Wet Mount	Urine Dipstick
	Group A Streptococcus
	Rapid Flu Test
	Rapid COVID Test
	HgB A1C
	UA Analyzer
	Drugs of Abuse Test

L. The state county code is 079.

M. All forms used for laboratory services are facility specific.

N. In-House Lab: Use of the preprinted EHR lab order form and the electronic health record (EHR):

1. RCDHHS uses the approved EHR to order and result all laboratory tests. (See *EHR Ordering and Resulting Laboratory Test Policy* in this manual.)

2. No verbal orders are accepted.

3. Orders must be already entered into the EHR. Tests to be performed are ordered in the EHR and encounter form and patient labels, if required, are accompanied with the specimen.

4. RCDHHS uses the EHR to print a copy of EHR printout before entering results in EHR and patient logs as test records.

5. Lab EHR orders should include:

   a. Patient name and DOB
   b. Test to be performed
   c. Date of specimen collection
   d. Practitioner and/or nurse order test
   e. Clinic patient is being seen in
   f. The name and address of the laboratory performing the test checked or circled
   g. Test results and units of measure if applicable.

6. Laboratory testing personnel perform in-house tests as ordered and record results obtained on all results on the preprinted out EHR lab orders. No results are given to the patient by laboratory technicians. Record in-house lab results in the EHR (Patagonia).

7. Copies of all preprinted EHR printouts with results are maintained on file for a minimum of 2 years.

8. Laboratory errors are followed up promptly in the EHR in the lab comment section. Documentation includes corrected result, date and time and corrected staff notification and lab personnel name. The correct lab data will be reported to the requesting provider or the clinic nurse. The correct data is to be entered in the EHR. The correction will be initialed and dated by the person making the correction. (See *EHR Corrected Reports Policy* in this manual.) Laboratory testing personnel will ensure all lab log sheets are updated with the correct data.

9. The EHR laboratory copy will be kept on file in the laboratory section for two years. After two years the lab copy will be destroyed.

O. Panic Values:

1. Panic or critical values and normal patient ranges, if applicable, are specified in this manual for that test.

2. For in-house panic values, the result is verbally given to the clinic nurse or provider. Panic lab values will be put in the EHR. The lab personnel will document in the comment section "Results verbally given to (type in person's name)."

3. Panic values and normal ranges are approved by the Clinical Consultant and reviewed annually.

P. Specimen Acceptability Criteria:

1. All specimens sent to the laboratory must be properly labeled with patient identification data, i.e., last name, first name, date of birth.

2. When the clinic nurse or practitioner orders labs in the EHR, the specimens are sent to the laboratory.

3. An unlabeled container or one labeled improperly will not be accepted by the laboratory. This will be recorded in the EHR and on the lab's paper copy of order.

4. If the patient identification on the specimen label is illegible, the specimen is unacceptable for laboratory testing. This will be recorded in the EHR and on the lab's paper copy of the order.

5. If the specimen container identification does not exactly match the order in the EHR identification for that patient specimen, the laboratory cannot accept the specimen. This will be recorded in the EHR and on the lab's paper copy of the order.

6. All specimen containers must be properly labeled immediately after collection by the person who performed the specimen collection. Lab staff will follow Lab-10 Policy, "Criteria for Obtaining, Preparing, and Mailing Specimens".

7. Laboratory testing personnel will notify the appropriate clinic nurse when unacceptable specimens are brought to the laboratory and recorded in the EHR on the lab's paper copy of the order. The clinic nurse will resolve the problem, i.e., recollect, reschedule.

8. The clinic nurse or provider is notified if a patient refuses collection or is unmanageable.

9. Disposition of rejected specimens is recorded on the patient log, in the EHR and on the lab's paper copy of the order.

Q. Reference Labs:

RCDPH laboratory utilizes the following reference laboratories for testing services beyond in-house testing capabilities:

NC State Laboratory of Public Health	#34D0692393
Quest Diagnostics	#11D0255931
Annie Penn Hospital	#34D0238568
Kansas State University (Rabies)	#17D0648239
Moses Cone Hospital	#34D0238982
Wesley Long Hospital	#34D0655119
Greensboro Pathology	**#34D0996909**

R. In-House and Reference Labs Logs:

1. Specimens sent to reference labs and in-house testing are documented daily on log sheets in order to track the disposition of the specimen and verify the receipt of test results.

2. The following is recorded on the daily test logs:

   a. Patient name and date of birth
   b. Date and time of test
   c. Clinic and provider ordering test
   d. "X" mark on the in-house testing log. A cross mark with the date of test above cross mark for outside reference lab. When lab results are in, the lab personnel writes the date under the cross mark and initials in red ink. If the lab results are

abnormal, the lab personnel will put an asterisk mark (*) beside each abnormal lab result.

3. Laboratory testing personnel will monitor reference lab log entries periodically to monitor receipt of results. When a patient's test result(s) has not been received in the routine turn around time, the reference lab or NCSLPH will be contacted to obtain the status of the patient results. The internet can be used to access RCDPH patient results from the NCSLPH and also Solstas Lab.

4. Completed logs are maintained in a file for two years.

S. Supplies:

1. All supplies in the laboratory will be marked with a "received date".

2. Each kit or reagent will include an open date. Expiration dates will also be documented on the quality control log. Each lab personnel performing QC and/or test should check inventory and expired on all controls and test kits.

3. If the expiration date after opening the container is different from the manufacturer's expiration date, the new expiration date must also be written on the container. This open expiration date can be found in the back of the Maintenance Manuals.

T. Responsibilities of Laboratory Personnel:

(See Attachments A, B, and C for checklists of duties.)

U. **Record Retention:**

1. All laboratory documentation (i.e., procedures, patient records, quality control, worksheets, patient testing records, GA, instrument printouts, PI and/or assay sheets, personnel records) is retained for a minimum of two years.

2. Refer to agency retention policy for specific guidance in laboratory records retention.

/di

ATTACHMENT A

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES

CHECKLIST FOR DAILY LABORATORY ROUTINE

Monday-Friday
8:00 a.m.

A. Open Laboratory:

1. Record all temperatures.
2. Set up and calibrate all instruments as required by CLIA regulations using correct controls for the following tests: Glucose, Hemoglobin, Urinalysis, Rapid Strep A, and Urine Pregnancy HCG.
3. Record results for above tests on Quality Control Sheets and plot on graph (save for 2 years).
4. Resub Oxidase Quality Control plates on Mondays.
5. Read and record GC plate results at 24, 48, and 72 hours as necessary. The Lab Technician who reads GC plates on the weekend or holidays should record the incubator temperature for that day.
6. If urethral specimen GC culture plates have growth, do Oxidase on control plate and Oxidase control of client's GC plate. If positive for Oxidase test on client's plate, do gram stain with control. The Oxidase control should be 1 negative and 1 positive result.
7. Mix 10% bleach solution daily for decontamination of used GC/Agar plates.
8. If throat or rectal GC culture plates have growth, these should be sent to the NCSL for confirmation testing. (See confirmation testing in the Technical Procedure Manual.

B. Process Laboratory Reports:

1. Monday through Friday the Lab Manager or Lab Technician will report to work at 8:00 a.m. and send lab reports to the ordering providers.
2. Lab reports from the NC State Lab of Public Health will be delivered to the lab after being date stamped by personnel.
3. Review lab reports in EHR from Quest Diagnostics. In the "comments section", initial report, save to ordering provider then close EHR. Record day returned on the lab log sheet. When receiving the NC State Lab of Public Health lab reports, initial lab reports in red ink, put and asterisk mark (*) beside any abnormals, and record day returned on the lab log sheet.
4. Verbal report to Advanced Practice Provider (APP) or program nurse on "panic values" for outside labs or in-house labs.
5. Distribute lab reports to APPs or program nurses.

C. Perform Laboratory collection or testing:

1. As ordered for clinic programs (WIC, Adult Primary Care, Pediatric Primary Care, Child Health, General Clinic, Family Planning, STD clinic, and Communicable Disease).
2. Do EKG's and **urine drug screenings for the Medication for Opioid Use Disorder (MOUD) clinic**.

3. Lab staff will follow Lab-10 Policy, "Criteria for Obtaining, Preparing, and Mailing Specimens". Record all specimens collected, tested, and/or sent out to Quest Diagnostics reference lab or SLPH on appropriate log sheets.

D. <u>In Between Laboratory Services for Programs</u>:

1. Do controls as required by CLIA regulation and per manufacturer. Lab staff will not perform client testing if QC is not in range or QC failure and if reagents have expired. Document all QC failures or problems on the problem log.
2. Work on paperwork, review and update laboratory manuals as necessary.
3. Review all daily sent out sheets, worksheets, file by the month and retain for 2 years. Review and verify that all in-house lab test results were entered in the EHR correctly by obtaining the copy of the preprinted EHR lab result sheet from the day before and checking it with what's entered into the EHR. (See *EHR Results Review Policy* in this manual.)

4 p.m. – 5 p.m. E. <u>Prepare Lab Specimens for Outside Laboratories:</u>

1. Ensure necessary forms are completed for all specimens. Lab staff will verify correct ID with the preprinted EHR lab result sheet.
2. Ensure tubes (specimen) are properly labeled. These should be double checked for correctness before lunch and at the end of the day by comparing lab requisition/order with specimen tube.
3. Ensure specimens are in the proper cans.
4. File EHR preprinted lab result sheet in the storage room file cabinet. Store daily log sheets in the file cabinet in the lab. Lock both cabinets. Check "Laboratory Log Pre-packing Specimen Verification" sheet two times daily.
5. Place specimens in outside collection boxes.
6. Clean and decontaminate all counter tops in the laboratory and nurses workroom.
7. Clean and decontaminate all surfaces and lab chairs. Throw out 10% used bleach solution down sink drain #2 in main lab. Clean equipment per manufacturer's instructions. (Please see lab equipment listing and care sheet in the Lab Maintenance Notebook.)
8. Change sharps containers as necessary.
9. Refill/restock supplies.
10. Cover microscopes.
11. Turn off equipment.
12. Check laboratory and workroom.
13. Turn off lights and close bottom half of laboratory doors and lock.

Date Developed: 1/99
Reviewed: 6/15; 10/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/13; 6/15; 10/15; 6/16; 6/17; 6/18; 6/24

ATTACHMENT B

ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHECKLIST FOR DAILY, WEEKLY, AS NEEDED, OR QUARTERLY DUTIES

Perform the Following:

A. Daily:

1. Open laboratory
2. Process laboratory reports
3. Perform laboratory collection or testing
4. In-between laboratory services as needed
5. Prepare lab specimens to send and check specimens to ensure correct ID and requisitions match. Decontaminate work area
6. Clean all surfaces with "Do It All" cleaner or "Disposable Germicidal Surface Wipes"
7. Clean equipment per manufacture's instructions (please see lab equipment listing and care sheet in the Lab Maintenance Notebook).

B. Weekly:

1. Check eye wash and initial maintenance log sheet for that date.
2. Clean candle jars and initial maintenance log sheet for that date.
3. Check incubator temperature when reading client's GC culture plates on the weekends or holidays then initial log maintenance log sheet for that date.

C. As Needed:

1. Sterility check on new GC plates on each lot number and each new shipment
2. Inventory and order supplies
3. Clean refrigerator with "Do It All Cleaner" or disposable germicidal surface wipes
4. Clean incubator with "Do It All Cleaner" or disposable germicidal surface wipes
5. Do preventive maintenance on all machines per manufacturers' instructions.

D. Quarterly:

1. Perform Quality Assessment per CLIA guidelines
2. Perform competency testing
3. Send to NCSLPH Technical Consultant
4. Meet with NCSLPH Technical Consultant
5. Oversee nurses' quarterly Quality Controls and Competency Testing
6. Perform proficiency testing when requested to do so by SLPH.

E. Yearly**:**

Per CLIA perform the "Quality Systems Assessment Checklist". A system on this checklist can be done monthly or quarterly**.**

Date Developed: 1/99
Reviewed: 6/15; 12/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/15; 12/15; 6/16; 6/17

ATTACHMENT C

ROCKINGHAM COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHECKLIST FOR ANNUAL LABORATORY DUTIES

Perform the following tasks annually:

1. Collect test totals for January 1st – December 31st. Send test totals and all requested information and forms to Technical Consultant by January 31st. Make copies of this information and retain for records.

2. Perform the "Quality Systems Assessment Checklist". A system on this checklist can he done monthly or quarterly.

3. In January and June of each year pull all lab policies from Lab Policy Manual, make copies (retain originals) and give to program leaders to update and compare Contract Addenda requirements.

4. After policies have been updated they should be placed in the Laboratory Policy Manual.

5. Laboratory staff must review and initial the Laboratory Policy Manual and Technical Procedures Manual – Annually.

6. Staff performing laboratory services must complete 6 hours for non-waived and 3 hours for waived personnel of continuing education. Staff performing only wet mounts are required to complete 4 hours of continuing education**.** Continuing education is sent to the NCSLPH Technical Consultant by January 31st.

7. Additional agency manuals to be reviewed and initialed are:

   a. OSHA Manual
   b. Technical Manual

8. Personnel will receive OSHA/Infection Control, Hazardous Material training upon hire and annually thereafter.

Date Developed: 1/99
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/16; 6/18

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: LAB – PERSONNEL ASSESSMENT AND COMPETENCIES

DATE DEVELOPED: 4/96
REVIEWED: 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/17

I. POLICY:

The Division of Public Health will strive to ensure that agency staff assigned to laboratory duties have received orientation and training to Laboratory Policies and Procedures. Staff assigned to laboratory duties should complete a Competency Skills Checklist prior to working independently in the laboratory setting. Agency staff are required to maintain proficiency status under CLIA Regulations and this is completed under the North Carolina State Laboratory of Public Health (NCSLPH) umbrella plan.

II. PURPOSE:

To ensure that agency staff performing laboratory services are trained and competent in the techniques of specimen collection, handling, testing, packaging, shipping, record keeping, and use of receiving order from EHR and for entering lab results in the EHR.

III. GUIDELINES:

A. The Laboratory Manager is responsible for the orientation and training of agency staff assigned to lab duties.

B. The Laboratory Manager is responsible for observing lab staff techniques in performing procedures and signing off each test when performed satisfactorily on the Competency Skills Checklist.

C. Agency staff assigned to laboratory duties are required to read and sign the Laboratory Policy Manual and Technical Manual during the orientation period and annually thereafter.

D. The laboratory staff should educate agency employees on any changes in policy or technical procedures and provide in-house training as necessary.

E. Maintaining Proficiency Status:

1. The contract defines the minimum testing necessary for testing personnel to maintain their level of proficiency.

2. Once a person is assigned to perform a laboratory test, he/she must perform the test at least once per quarter or be eliminated from doing the test.

3. If the person is doing the test only once per month or less, he/she must perform quality control on that test each day he/she does the test.

4. Competency assessment is performed four times a year. This is under the CLIA Regulations and is provided by the NCSLPH umbrella plan. The technical consultant sends these unknown specimens to the agency. Each person that performs lab tests is required to perform this duty. If staff fails competency the Regional Consultant will write a follow-up plan for remediation.

IV. RECORD KEEPING:

A. The Laboratory Manager is responsible for overseeing orientation, training, and monitoring proficiency status for all agency staff performing lab services.

B. Personnel files are completed on all lab staff employees with a brief summary of education and current job description and a list of duties pertaining to lab procedures.

C. Documented continuing education is required by CLIA which is 3 hours for persons performing waived procedures, 6 hours for non-waived procedures, and 4 hours is needed for persons performing wet mounts. The documentation is required by the Technical Consultant from the NCSLPH to ensure compliance.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: QUEST DIAGNOSTICS ACCESSING LAB RESULTS ELECTRONICALLY

DATE DEVELOPED: 6/13
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 11/23; 6/24
REVISED: 6/14; 6/18; 11/23

I. POLICY:

The Division of Public Health will offer accurate and timely lab results for all departments using Quest Diagnostics for patient testing. This is a secure patient information site that allows designated personnel to access patient clinical lab results.

II. PURPOSE:

To gain access to patient laboratory test reports, this will expedite care for that individual.

III. GUIDELINES:

Method – Designated personnel may access Quest Diagnostics by the following:

1. **Log on to questdiagnostics.com.**
2. **Click on "Lab Services Manager".**
3. Type in user name and password.
4. The page should come up with **"**New Lab Results". Click on "New Lab Results" and look for the client or enter the client's name (last name then first name) at the top right of screen.
5. The report should come up

TO LOOK UP A TEST -

6. After you "Log In" (step # 3 above), click on **"**Quest Diagnostics" on top right of screen. Click on "Physicians and Hospitals" then click on "Test Center" on left side of screen.
7. When the page comes up, type in the name of the test, test code, CPT or key word under "Search for Test or Guide".

CALL QUEST DIAGNOSTICS AT 1-866-697-8378 IF ANY QUESTIONS

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: LABORATORY SAFETY AND QUALITY ASSURANCE

DATE DEVELOPED: 6/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/18

I. POLICY:

The Division of Public Health Laboratory staff will strive to follow standard of precautions at all times when providing direct care to clients. The terms "universal precautions" and "standard precautions" are used through the Division of Public Health Policies and Procedures interchangeably. Laboratory staff will follow the Agency's Infection Control Policy and OSHA Laboratory Safety Guidelines (see OSHA manual). Laboratory Staff will follow the Laboratory Technical Manual for procedures for collecting, packaging, transporting or shipping specimens.

II. PURPOSE:

To treat all blood and body fluids as if they are infected for the purpose of reducing the incidence of infection by blood Bourne pathogens. To promote a safe working environment for the laboratory staff that includes properly functioning equipment and testing materials.

III. GUIDELINES:

Bloodborne pathogens are a major occupational health hazard in the laboratory setting. Engineering controls, work practice administrative controls, and personal protective equipment must be used to eliminate or minimize exposure to bloodborne pathogens or other potentially infectious material.

A. Assume that blood and body fluids containing visible blood from all clients are potentially infectious.

B. WASHING HANDS – Hands must be washed before and after contact with each client. Hands should be washed under a steady stream of water with an appropriate antibacterial solution. In the absence of water, an appropriate antibacterial solution must be used until the time that running water and antibacterial solution are available. Agency prefers the usage of paper towels when available and liquid soap not bar soap.

C. GLOVES – such as vinyl or latex medical gloves, must be worn when having direct contact with blood, body fluids, mucous membranes or non-intact skin, when handling items soiled with blood, or when handling

equipment contaminated with blood or body fluids. Gloves should properly fit. This includes, but is not limited to the following:

1. The handling of grossly contaminated clothing or articles
2. Empty trash
3. Venipuncture or other vascular access procedures
4. When cleaning reusable equipment.

Laboratory staff should wear gloves when "their" hands are abraded or when active dermatitis is present. Gloves should be changed after each client contact and if they tear or are punctured. When gloves are removed, through hand washing is required; gloves do not take the place of hand washing and should be changed between any procedures. Heavy utility gloves may be worn during routine decontamination cleaning procedure. Rings with raised points should not be worn under gloves.

D. GOGGLES or PROCTECTIVE GLASSES – should be worn when there is potential for a splash with blood or body fluids. Examples include venipunctures.

E. LAB JACKETS, GOWNS OR APRONS – a barrier-proof gown should be worn when there is a potential for blood or body fluids splatters or sprays. Lab jackets should be closed (buttoned or snapped) while working and removed when leaving the clinic area. Lab staff should change jackets daily or when visible body fluids are present.

F. MASKS – are usually not necessary if contact is only casual, but should be worn if there is a chance of splash or splatters or the client is on respiratory precautions. Masks are worn only once and discarded; masks become ineffective when moist, usually after 20 minutes of use.

G. AIRWAYS – Although saliva has not been implicated in HIV transmission, a one-way airway, mouthpiece, resuscitation bag or other ventilation device should be available when resuscitation is predictable for use during actual resuscitation. Emergency PPE is made available in the lab and workroom.

H. In the event of contamination with blood or body fluids, body surfaces should be washed immediately with soap and water.

I. All laboratory specimens should be treated as if they are contaminated with HCV, HIV, and HBV. All specimens should be clearly marked as such and transported in a well-constructed container with a secure lid with care taken to avoid contaminating the outside container. All procedures involving blood or other potentially infectious material must be performed in such a manner to minimize splashing, spraying, spattering and generation of

droplets of these substances**.** Lancets and vaccutainers/needles are to be disposed of after each client and use a sterile one with each client**.**

J. For disposal of contamination supplies other than needles, double bagging techniques should be used. Areas and equipment contaminated with blood should be cleaned as soon as possible with 1:10 bleach solution or "Do It All Cleaner". Equipment can also be cleaned thoroughly and soaked in 70% isopropyl alcohol for ten minutes to inactivate HIV. Fresh bleach solution must be made daily, and then discarded.

K. Soiled articles (eg. lab coats) should be handled as little as possible and with minimum agitation to prevent gross microbial contaminations of the air and of persons handling the articles. Articles soiled with blood or body fluids should place and transported in bags that prevent leakage.

L. Laboratory Staff cleaning biological spills or contamination equipment should wear gloves and take care not to contaminate clothing. Disinfectant-detergent formulas (such as "Do It All Cleaner") registered by the EPA can be used for cleaning environmental surfaces, but the actual physical removal of microorganisms by scrubbing is probably more important than any microbial effect of the cleaning agent used. The surface should be treated with a second application if recommended by the cleanser used.

M. Counter tops are to be cleaned daily with "Do it All Cleaner" or "Disposable Germicidal Surface Wipes". Staff assigned to lab will be responsible for cleaning.

N. Do not allow clients to leave laboratory until bleeding has stopped.

O. Laboratory staff members with exudative lesions or weeping dermatitis should refrain from all direct client care and from handling client care equipment until condition resolves, or provide a protective dressing to prevent client-cross contamination.

DISPOSAL OF CONTAMINATED ITEMS:

All contaminated items will be disposed of in a manner that will protect clients, caregivers and employees from exposure to microorganisms/viruses.

A. Always wash hands before and after contact with contaminated items and exercise extreme care to prevent accidental contamination or exposure to the contaminated items.

B. Gloves are always worn to handle contaminated supplies. Gowns or aprons should also be worn if there is a large spill or contaminations. If the outside of a container becomes contaminated, employees must handle the container

with gloves while placing the contaminated container inside a second leak proof, biohazard-labeled container with a secure lid. Contaminated lab forms should be disposed of with regulated waste or autoclaved.

C. Place all contaminated items (dressing supplies) in a plastic bag. ALWAYS DOUBLE BAG CONTAMINATED ITEMS.

D. Remove gloves, place used gloves in the bag and secure the bag.

E. Wash Hands

F. Place properly secured waste in the regular trash-double bagged.

G. Contaminated liquids (urine, blood/body fluids) may be flushed down the sewer system. The facilities should be cleaned daily with chlorine bleach solution or "Do It All Cleaner". All excretions should be flushed down the toilet.

H. Disposal of GC test plates should be decontaminated with 10% bleach solution for 15 minutes and then discarded in regular trash.

I. Laundry should be considered contaminated and handled with gloves.

1. It is recommended that laundry be washed separately with detergent water which is at least 160 degrees Fahrenheit for at least 25 minutes.
2. If the water is of a lower temperature, an appropriate disinfectant solution should be added, for example, bleach. The Division of Public Health uses a commercial laundry service.

DISPOSAL OF NEEDLES, SYRINGES AND SHARP ITEMS:

All needles, lancets, Vaccutainers and sharp items such as slides are disposed of in securely fastened rigid, puncture-proof, labeled containers. Care should be taken to protect clients, caregivers and provider employees from needle sticks or injury and exposure to microorganisms/viruses.

A. To prevent needle sticks injures, needles should never be recapped, bent or manipulated by hand. These items and other sharp items such as lancets, razor blades, etc should be considered potentially infections and handled with extraordinary care. Used needles should be placed intact into puncture resistant containers. The container, when 2/3 full is properly disposed of in accordance with arrangements made by the agency for disposal. Contractual services are used for Bio-Hazard Medical Waste Pick-up. Nurses return the sharps containers to the agency Bio-Hazard Medical Waste Box. It is recommended that the lids be taped securely.

B. Blood collection tubes, Hemocue cuvettes, and capillary tube vials are to be collected in puncture resistant containers. For confidentiality, ensure client information on the labeled specimens is facing the wall when placed in tube holder racks.

ISOLATION PRECAUTIONS:

Standard precautions with protective equipment constitute the most highly effective isolation precautions.

A. Masks should be worn when caring for clients when contact with respiratory droplet secretions are anticipated.

B. Respiratory precautions are instituted for suspected or confirmed infectious TB clients.

C. The diseases for which respiratory precautions are indicated are TB (pulmonary or laryngeal), chickenpox, influenza and meningitis (until 24 hours after the start therapy).

MEDICAL EQUIPMENT:

A. Additional work practices for laboratory personnel:

1. Cover tops of vacuum tube with absorbent sponge, open away from employee.
2. Change gloves and wash hands after completion of specimen processing.
3. Mouth pipetting/suctioning is prohibited. Use mechanical devices for all pipetting.
4. During centrifugation, use a safety centrifuge cup of fiberglass shield to prevent aerosolizing of the contents.
5. All laboratory personnel must remove personal protective equipment and wash their hands prior to leaving the laboratory.
6. Access to the laboratory is limited or restricted to laboratory personnel and housekeeping.
7. All equipment, work and environmental surfaces must be cleaned and decontaminated with Do It All Germicide Foaming Cleaner or an EPA-approved disinfectant that is tuberculocidal and antimicrobial with HIV efficacy claims, such as phenolic or quaternary ammonium germicidal detergent solution, once a day and after any spill of potentially infectious material.

    a. Laboratory work surfaces should be impervious and easily cleanable.

b. Any material used to cover equipment and environmental surfaces must be removed and replaced as soon as possible when they become overtly contaminated or at the end of the work shift if they become contaminated during the shift.
c. 10% bleach solution should be mixed daily and stored for decontamination of GC/Agar plates when testing is completed.

8. Equipment that may become contaminated with blood or other potentially infectious material must be examined and decontaminated with Do It All Germicide Foaming Cleaner or an EPA –approved disinfectant, such as phenolic or quaternary ammonium germicidal detergent solution, prior to servicing or shipping.
9. All specimens of blood or potentially infectious material are transported only in a well-constructed biohazard labeled containers with a secure lid to prevent leakage during collection, handling, processing, storage, transport or shipping. Contamination of the outside of the container and of the laboratory form should be avoided.
10. All urine specimens are to be placed in trays located between bathrooms and laboratory. Specimen containers is to be labeled with clients name, clinic. Assistant working in diabetic clinic, child health or adult health will collect urine specimen in laboratory and do urinalysis in laboratory. For confidentially ensure labeled urine specimens are facing the wall when placed in the specimen holding trays.
11. No eating or drinking in the laboratory (Room 25).
12. All specimens of blood and body fluids should be put in a well-constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and the laboratory form accompanying the specimen.
13. All blood specimens leaving lab must carry a biohazard label.
14. In case of accidental chemical or blood exposure to eyes, eye wash is located in the Nurse Work Room # 24.

<u>SAFETY CONTROL MEASURES</u>:

A. 1. The lab area is equipped with the following safety measures.

- Adequate entrances and exits
- Eye wash
- Goggles
- Face shields
- Spill kits

- Fire extinguishers
- Controlled air flow

2. The lab will appropriately draw, handle and test specimens in the lab.
3. All lab logs will be kept for two years.

B. Equipment/test material safety

1. All test materials are checked daily to ensure temperature and expiration dates are within acceptable limits.
2. Controls are run daily and recorded in work logs.
3. Outdated materials are disposed of according to recommendations.
4. Equipment is checked daily for proper functions and records kept of function and repair.
5. Microscopes are cleaned daily and serviced on a yearly basis by a professional optical company.
6. Centrifuges are balanced with evenly filled of specimen tubs while in use. Urine centrifuge are returned to manufacture for service and/or repair. Call Quest Diagnostics for blood centrifuge problems.
7. See back of Equipment Maintenance log in the lab for complete list of equipment listing and care or see "Test Systems Backup Plans Policy (LAB-29).

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: IN HOUSE NORMAL LABORATORY VALUES

DATE DEVELOPED: 6/93
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 11/23; 6/24
REVISED: 2/16; 6/16; 6/17; 6/18; 6/22; 11/23; 6/24

I. POLICY:

The Division of Public Health Laboratory staff will follow the Laboratory Technical Manual for procedures in collecting, handling and testing, in-house lab specimens for programmatic clinical services. Laboratory services provided will be determined by each program's guidelines and/or Advanced Practice Provider (APP) orders. The APP or program nurse will order the necessary labs for the laboratory staff in the EHR, to ensure appropriate tests are performed.

II. PURPOSE:

To ensure proper collection, handling and testing of in-house lab specimens. To reduce the risk or error, provide the best quality specimens for testing and provide accurate test results.

III. GUIDELINES:

A. Glucose

Fasting		74 mg/dl – 106 mg/dl
Random	(Non-Diabetic)	<140 mg/dl (65-139 mg/dl)
	Diabetic	<180 mg/dl (65-179 mg/dl)

B. Hemoglobin

Infants after neonatal	11.1 – 14.0 g/dl (WIC standards)
Children 2 years – 13 years	gradually increase to adult normals
13 years & up:	
females	12.0 – 15.0 g/dl
males	13.0 – 17.0 g/dl

C. Urinalysis – Chemical Test Strips

Color	Yellow/Clear
Appearance	Colorless
Leukocytes	Negative
Nitrates	Negative
Urobilinogen	Normal – <1mg/dl
Protein	Negative-trace
pH	5-9
Blood	Negative
Ketone	Negative
Bilirubin	Negative
Glucose	Normal

D. **Hemoglobin A1C: 4.8 – 5.6%**

E. Urine Microscopic

WBC	0-5/hpf
RBC	0-5/ hpf
Epithelial cells	0-3/hpf
Casts	Occ Hyaline/lpf
Bacteria	Rare/hpf
Crystals	Negative/lpf
Mucus	negative-small

F. Miscellaneous:

Fecal Occult Blood	Negative
Presumptive for Neisseria gonorrhea	Not found
Urine Pregnancy Test	Negative
Wet Mount	Negative
Rapid Group A Streptococcus	Negative
Rapid Flu	Negative
Rapid COVID	Negative

IV. REPORTING:

A. Values within normal or abnormal range (See 4 below).

B. Abnormal Values are any values out of normal range but not within a panic value.

C. Panic Values – are those values that are in the "high risk" area for immediate problems or life threatening occurrences. Panic values are relayed verbally to the APP as soon as possible and entered into the EHR that panic level was reported to the clinic nurse or APP.

D. Lab Report / Test Results:

1. Laboratory staff will log in all reports completed by in-house, state laboratory or contracting laboratories. In-house results will be put in the electronic health record. Quest Diagnostics reports will be sent to the ordering provider via EHR.
2. Panic values will be recorded in the panic log book and reported verbally to the APP or program nurse if APP is unavailable and entered into the EHR that panic level was reported to the clinic nurse or APP.
3. Laboratory staff will give all lab reports/test results via EHR to the appropriate APP or program nurse for appropriated follow-up.

4. In the absence of the APP or program nurse reports will be given to the Clinical Nursing Supervisor.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: IN-HOUSE PANIC LAB VALUES

DATE DEVELOPED: 6/93
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 11/23; 6/24
REVISED: 6/16; 6/17; 6/22; 11/23

I. POLICY:

The Division of Public Health laboratory staff will report all in-house panic value lab results to the appropriate Advanced Practice Provider (APP), program nurse and/or Clinic Supervisor and record results in the Panic Log Book.

Panic Values are those values that are in the "high risk" for immediate problems or life threatening occurrences. They are relayed verbally to the APP as soon as possible.

II. PURPOSE:

To reduce the risk of life threatening problems and aid early intervention/treatment or to reduce the spread of disease.

III. GUIDELINES:

A. Blood Glucose

Capillary Blood

Fasting Glucose < 60 mg/dl repeat test and give verbal report to APP or program nurse and enter who lab staff reported to in the correct section of the EHR.

Glucose ≥ 400 mg/dl repeat test and give verbal report to APP or program nurse and enter who lab staff reported to in the correct section of the EHR.

B. Hemoglobin

≤ 10.0 g/dl	repeat test and give verbal report to APP or program nurse and enter who lab staff reported to in the correct section of the EHR.
>17.0 g/dl	repeat test and give verbal report to APP or program nurse and enter who lab staff reported to in the correct section of the EHR.

C. Fecal Occult Blood positive

D.	Urine Preg Test	positive
E.	Presumptive for Neisseria gonorrhea	found
F.	Rapid Group A Streptococcus	positive
G.	Rapid Flu	positive
H.	Rapid COVID	positive
I.	**Hemoglobin A1C**	**≥ 14.0%**

IV. REPORTING:

1. Panic values will be reported verbally to the APP or program nurse, if APP is unavailable.

2. Laboratory staff will give all lab reports/test results via EHR to the appropriate APP or program nurse for appropriate follow-up. In the comment section in the electronic health record, document "Results verbally given to (*type in name of person*)."

3. In the absence of the APP or program nurse reports will be given to the Clinical Nursing Supervisor.

4. Document results and contact information on the client's requisition and in the Panic Log Book. Retain for 2 years.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ABNORMAL VALUES

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 6/16; 6/17; 6/18

I. POLICY:

The Division of Public Health Laboratory staff will put and asterisk mark (*) beside any outside abnormal lab values from the state lab. Abnormal in-house lab results are given directly to the ordering Advanced Practice Provider (APP) via the EHR. Quest Diagnostics results are received via EHR and lab staff sends results to the provider via EHR.

Abnormal Values –

Abnormal values are any values out of normal range; normal range being defined by the laboratory conducting test and/or agency policy but not within a panic value.

II. PURPOSE:

To reduce the risk of life threatening problems and aid early intervention/treatment or to reduce the spread of disease.

III. GUIDELINES:

A. Laboratory staff will log in all reports completed by in-house, state laboratory, or contracting laboratories. In-house lab results will be put in the electronic health record.

B. Elevated or low values – (outside normal range from the state lab or Penn Nursing Program) should have and asterisk mark (*) beside abnormal results and the report given to the APP or program nurse for program appropriate follow-up.

C. Lab reports should be given to the following APPs or program nurses for program appropriate follow-up:

- Adult Primary Care APPs
- Pediatric Primary Care APP
- Diabetes Program Coordinator
- Family Planning APP
- Communicable Disease Program Coordinator
- Sexually Transmitted Disease (STD) Program Coordinator
- WIC Program Supervisor
- Child Health Program Coordinator

- Lead Program Coordinator
- Sickle Cell Program Coordinator

IV. REPORTING:

A. Laboratory staff will give all lab reports/test results to the appropriate APP or program nurse for appropriate follow-up via EHR. In-house lab results will be put in the electronic health record. Quest Diagnostics lab results are sent to the ordering provider via the EHR.

B. In the absence of the APP or program nurse, reports will be given to the Clinical Nursing Supervisor.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: REPORTING AND RECORDING OF LABORATORY DATA

DATE DEVELOPED:
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 2/16; 6/16; 6/17; 6/18

I. POLICY:

The Division of Public Health Laboratory staff will report and record laboratory data as set forth by State and Agency guidelines.

II. PURPOSE:

To ensure the reporting and recording of lab test results and detect clerical errors, significant analytical errors and unusual laboratory results.

III. GUIDELINES:

A. Reference Lab Results

1. Lab staff will send Quest Diagnostics lab results to ordering provider via EHR.

2. Lab staff will record on lab log sheets the date results received.

3. All abnormal readings from state labs should have an asterisk mark (*) beside all abnormal lab results. Any panic value levels will be verbally reported to the program Advanced Practice Provider (APP), Program Nurse, or in their absence the Clinical Nursing Supervisor and in the correct section in the EHR, enter who and when panic value was verbally reported. If pap results required additional testing for HPV, the lab personnel will pull charge sheet and attach it to the lab pap results.

4. Reports are given to the designated person after lab staff reviews and records on log sheets. The reports are given to the appropriate APP for follow up. Clerical support will place report in client's chart and will record date posted beside results and initialed by staff.

B. In-House Results

1. Record on the laboratory clipboard the client's name, date of birth, date/time specimen was drawn and initial of testing personnel. Mark an "x" on the correct test that was performed. Client lab results are recorded on a preprint out of the lab order in the EHR. Record lab results in the electronic health record. Save and close.

2. Results may be recorded in the client's record by PHN in the electronic health record (EHR) according to program policies. (Refer to Standing Laboratory Orders for program areas.)

3. All clients are interviewed and laboratory results may be given by a nurse. If results are abnormal, the client is referred to the APP for evaluation. (Refer to the Normal Range Values in the Policy Manual).

4. APPs and nurses tell clients that they will be notified by letter or phone to return to the Department for results of lab and diagnostic studies if they are abnormal. The APP may give abnormal lab results via phone. If written by the APP, nurses are allowed to give abnormal lab results and advise clients as needed.

5. If lab results are normal, the clients are told they will be not be contacted.

6. All abnormal readings from state lab should be marked with an asterisk mark (*) beside each abnormal result. Any panic value abnormals will be verbally reported to the APP, program nurse, or clinical nursing supervisor in clinic, in their absence, along with the written report.

7. All Quest Diagnostics lab results will be sent via EHR to ordering APP.

8. All lab results will adhere to the Confidentiality Policy Procedure Manual.

9. No lab results are to be taken or given by front office personnel; these should go to laboratory staff.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: OFF-SITE TESTING

DATE DEVELOPED: 6/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 9/06; 3/08; 3/09; 3/10

I. POLICY:

The Division of Public Health offers screening at Health Fairs, Industrial and Community Screenings for blood pressure and capillary blood glucose.

The Division of Public Health laboratory staff will follow the Off-Site Testing Manual for procedures in collecting, handling, and testing off-site lab specimens.

II. PURPOSE:

To ensure proper collection, handling, and testing of off-site lab specimens. To reduce the risk of error, provide the best quality specimen for testing and provide accurate test results.

III. GUIDELINES:

A. Laboratory staff or clinical staff assigned to the off-site test area must have available and follow the written policies and procedures located in the Off-Site Testing Manual.

B. The Off-Site Testing Manual contains the following:

1. Procedure for test method

2. Site qualifications log sheet for screening (temperature, power, conditions)

3. Instructions for transport and set up of equipment

4. Quality Control procedures, documentation

5. Reference ranges for Quality Control and clients

6. Standing Orders

7. Training documentation of testing personnel can be located in the Management Personnel Manual.

8. Any relevant Quality Assurance records

9. PTM forms and documentation (logs, EHR preprinted order sheet, reports)

C. Off-site laboratory test performed:

- Capillary Blood Glucose

IV. REPORTING:

A. Values within normal range – (see D-3 below).

B. Abnormal Values – are any values out of normal range but not within a panic value.

C. Panic Values – are those values that are in the "high risk" area for immediate problems or life-threatening occurrences. Panic values are relayed verbally to the client's physician as soon as possible by the lead nurse assigned to the off-site test area.

D. Lab Reports/Test Results –

1. Laboratory staff will log in all lab results on the appropriate log sheet in the Off-Site Testing Manual and log sheets will be stored at the agency per agency protocols.

2. Panic values will be reported verbally to the client's physician as soon as possible by the lead nurse assigned to the off-site test area.

3. Lab values within normal range will be recorded on the log sheet and client screening forms.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: STATE LAB WEBSITE

DATE DEVELOPED: 4/11
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 2/16

I. POLICY:

The Division of Public Health will offer accurate and timely lab results for all departments using the State Laboratory of Public Health for patient testing. This is a secure patient information site that allows designated personnel to access patient clinical lab results.

II. PURPOSE:

To gain access to patient laboratory test reports, this will expedite care for that individual.

III. GUIDELINES:

Method – Designated personnel may access the North Carolina State Laboratory of Public Health by the following:

1. Open the Internet Explorer.

2. Access The North Carolina State Laboratory of Public Health by typing in http://slph.ncpublichealth.com/microbiology/defaultlasp in the address box.

3. The NCPH Login screen will appear. Enter

   EIN: 566001527

   Your personnel information:

   USER ID:
   PASSWORD:

4. Click *Login.* Continue to the Home – Welcome page.

5. Click on *Lab Test* at the top of the page.

6. Select appropriate Lab:

   *Adult Sickle Cell
   *Blood Lead

*Chlamydia
*Enteric
*Hepatitis
*HIV
*Myco-TB
*Mycology
*Newborn Screening
*Parasitology
*Special Bacteriology
*Syphilis
*Viral

7. Enter patient's *Birth Date* (m/d/yyyy).

8. Click *Search*.

9. Select correct patient. Lab results will pop up. These results may be printed if needed.

NOTE:

If Conflict Box pop up appears, lab results will not be available until the conflict has been reconciled. Contact State Lab @ 919-733-7544 and ask for appropriate testing lab (i.e. Serology, Newborn Screening, etc.) to reconcile the conflicting information. Afterwards all results will be viewable.

RULES:

The North Carolina State Laboratory of Public Health Website is a secure Clinical Lab result information site that should not be abused. All agency and HIPAA regulations apply.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CRITERIA FOR OBTAINING, PREPARING, AND MAILING SPECIMENS

DATE DEVELOPED: 5/13/93
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 11/23; 6/24
REVISED: 2/16; 6/17; 6/18; 6/22; 11/23

I. POLICY:

It is the policy of the Division of Public Health lab in collaboration with Public Health Officials, to reserve the right to decide whether or not to analyze samples or specimens.

II. PURPOSE:

Clinical specimens must be properly labeled. Every tube, vial or other specimen container must be labeled with the patient's name and date. Lab personnel will verify patient's name and date of birth with labels by asking patient his/her name and date of birth. Unlabeled clinical specimens will be discarded. Clinician will be requested to collect another specimen.

III. GUIDELINES:

The guidelines below are referenced from the NC State Laboratory (Scope Manual) and Lab Technical Manual.

A. Procedure for Collecting Blood Samples:

1. Identify client by asking client to repeat first and last names, and date of birth.

2. Gather appropriate tubes and label with client's name and date of birth before drawing blood.

3. In case of anonymous testing, ask for ID number.

4. Label tube as follows:
   - last name
   - first name
   - date of birth

   Set tubes upright in appropriate container with name facing wall to maintain confidentiality, allow to stand 30 minutes to allow to clot.

5. Spin, separate into appropriate tubes and label. Lab personnel will check for proper labeling of specimen and sign the "Laboratory Log Pre-packing Specimen Verification" sheet two times daily.

   - Purple – HA_1C, CBC
   - Blue – PT, PPT
   - Red/Serum Separator – Chemistries, Serologies

6. If sent out to reference lab, mail with appropriate lab forms – with all client information complete.

   State Lab – SL Annie Penn – AP
   Quest Diagnostics

7. Discard clot tubes in biohazard container.

8. Verbal orders are not accepted. All requests for SLPH should be made by filling out appropriate requisition completely with time, date, diagnosis code, provider's name, all patient's information required and billing information as well as test marked using small "x" marks.

9. Quest Diagnostics and Penn Nursing Program will be ordered in the EHR by the clinic nurse or ordering Practitioner.

B. Preparation:

1. Serum separator tubes are allowed to clot, properly spun down for 10 minutes, separated, and put into transfer tubes labeled with client name (first, last, middle initial) and date of birth if sending to the State Lab. These transfer tubes will be checked for correct patient ID against the serum separator tube twice, and then the transfer tubes will be checked again with the requisition order before placing the specimen and requisition in the mailing container. Serum separator tubes do not need to be transferred into transfer tubes if sending to Quest Diagnostics and will be checked for correct patient name and date of birth against orders.

2. All blood samples drawn will need name and either SSN or date of birth on transfer tube or original vacutainer tube.

3. Purple tubes are not usually spun but kept refrigerated and shipped as whole blood unless it is a special test and Quest Diagnostics requires it to be spun down, poured off, frozen, etc.

C. Mailing:

1. All blood specimens are transferred to appropriate lab site in biohazard containers, labeled as such:

State Lab – Transferred by Courier
Quest Diagnostics – Transferred by Quest Courier
Local Hospitals – Transferred by Hospital Courier

2. All specimens going out to a reference lab will be checked two times for accuracy with the orders before sending out.

3. For State Lab blood specimens **place each specimen and absorbent material in its own color-coded bag.**

4. **Fold and slide completed requisition into pouch on bag.**

5. **Add the appropriate temperature label to the large courier bag.**

6. **Canned specimens (enteric, parasitology, mycology): Fragile specimens must be shipped in crush-proof containers. Place in large bag with appropriate label attached.**

7. **Courier will pick up labs daily.**

8. For other mailing services refer to the packaging and shipping IATA Regulation instructions Scope Manual. Call SLPH at 919-733-7544 for instructions.

D. Procedure For Obtaining/Mailing Urine Specimens:

Urine specimens are collected in specimen cups, labeled with client name and placed in pass through door between lab and bathroom. Each specimen should have orders in the EHR. Specimens requiring culture and sensitivity are transferred to a sterile bacterial culture tube, properly labeled and sent to the reference lab then placed in labeled biohazard bag. If urine drug screen is ordered, specimen should be collected in a Quest Diagnostics sterile collection cup and then refrigerated with other Quest specimens.

E. Procedure for preparing Pap test for Quest Diagnostics Lab:

Correct Quest Diagnostics cytology orders via EHR should be filled out in entirety with date, time of collection, ordering provider's name marked, patient's information, billing information, reason for test, source, LMP, any clinical information, diagnosis code and test to be ordered marked.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT REFUSAL OF COLLECTION, REJECTION OF SPECIMENS, AND UNSATISFACTORY SPECIMENS

DATE DEVELOPED: 7/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15

I. POLICY:

The Division of Public Health Laboratory staff will follow the Laboratory Technical Manual and State Guidelines for client refusal of collection of specimens, rejection of specimens and unsatisfactory specimen.

II. PURPOSE:

To ensure proper collection, testing, packing of lab specimens to reduce the risk of error and provide accurate testing results.

III. GUIDELINES:

A. CLIENT REFUSAL OF COLLECTION

1. The Division of Public Health respects the right of a client to refuse to have blood drawn. If this occurs, notify the person in charge of that department and document in the client's electronic health record (EHR) that they refused to have blood drawn by the program nurse.

2. Client should be informed that their refusal may not impact their continuation of care, but may impede the process of diagnosis or treatment.

B. REJECTION OF SPECIMENS

The lab will not accept specimens that are not labeled with client's name on the container or an EHR order. The specimen will be discarded and the lab will notify the Advanced Practice Provider (APP) or program nurse to obtain another specimen.

C. UNSATISFACTORY SPECIMENS

If while obtaining a specimen or during the testing process something goes wrong, for example – Specimen tube breaks during centrifuging, the specimen would be unsatisfactory and the lab would have to recollect the specimen. This would be documented in the electronic health record (EHR) and on the client's clinical record by the program nurse.

VI. REPORTING:

For client refusal or recollection of specimen, notify the APP or program nurse and document on client's clinical record.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: IN-HOUSE REJECTION OF SPECIMENS

DATE DEVELOPED: 6/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/22

I. POLICY:

The Division of Public Health Laboratory staff will follow the Laboratory Technical Manual and OSHA Guidelines for rejection or disposal of specimens.

II. PURPOSE:

To ensure all lab specimens are handled and processed correctly, reduce the risk of error and provide accurate results.

III. GUIDELINES:

The guidelines below are OSHA or STATE guidelines:

A. Glucose:

1. Inadequate amount of blood
2. Incorrect timing
3. Expired cuvettes
4. Air bubbles
5. Inadequate puncture

B. Hemoglobin:

1. Inadequate amount of blood
2. Incorrect timing
6. Expired cuvettes
7. Air bubbles
8. Inadequate puncture

C. Urinalysis: Chemstrip 10 pad or Chemstrip 2 pad

1. No name on cup
2. Grossly bloody specimen
3. Specimen older than 1 hour and has not been refrigerated
4. Failure to collect in a clean container
5. Inadequate specimen – need 5ml if possible

D. Urine Microscopy:

1. Inadequate specimen- needs 5 ml if possible

2. Failure to obtain a clean catch midstream specimen
3. Specimen is older than 2 hours - sitting at room temperature
4. No name on cup

E. Urine Pregnancy Test:

1. No name on cup
2. Inadequate specimen (2-4ml)
3. Collected before HCG becomes detected

F. Wet Mount:

1. No name on cup
2. Run test as soon as possible
3. Inadequate specimen more than 1 ml saline
4. Cold specimen – keep warm 35ºC

G. Fecal Occult Blood:

1. No name on specimen
2. Inadequate specimen (too small or large sample)
3. If red meats or beets were eaten 2 days before testing

H. Urethral Male Smear:

1. No name on slide
2. Inadequate specimen
3. Specimen on wrong side of slide and is washed off during staining process

I. GC Culture:

1. No name on culture plate
2. Inadequate specimen
3. Cultures left out of incubator overnight
4. Incubated longer than 72 hours
5. Failure to place culture in CO_2 jar
6. Incubator not working properly and/or temperature not within 35-37ºC range
7. Expired culture plate

J. Hemoglobin A1C:

1. Specimen has remained in the glass capillary for longer than five minutes prior to analysis
2. Highly lipemic samples
3. Inadequate specimen

K. Influenza A & B Antigen:

1. No name on specimen swab
2. Specimens stored < 2ºC or > 25ºC
3. Specimens greater than 8 hours old

L. SARS CoV-2 Antigen:

1. No name on specimen swab
2. Specimens stored < 2ºC or 8ºC
3. Specimens greater than 120 hours old when stored at room temperature

M. COVID-19/Flu A & B Antigen:

1. No name on specimen swab
2. Specimens greater than 4 hours old when stored at room temperature
3. Specimens greater than 8 hours old when stored at 2-8ºC
4. Specimens stored in transport media

N. Rapid Group A Streptococcus:

1. No name on specimen swab
2. Specimens greater than 72 hours old

IV. REPORTING:

A. If any of the above occurs, the specimen would be rejected and disposal of the specimen would be done according to OSHA Guidelines. Documentation would be done in client's clinical record and in the electronic health record (EHR) by the program nurse or the Advanced Practice Provider (APP).

B. Reference Labs Rejection of Specimen -

Refer to each lab Policy Manual for their guidelines on specimen rejection.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: QUALITY CONTROL FAILURE POLICY

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/18

I. POLICY:

The Division of Public Health Laboratory staff will follow the Laboratory Technical Manual and State Guidelines when laboratory controls are out of shift, trend, or range.

II. PURPOSE:

To ensure proper action is taken to correct laboratory controls.

III. GUIDELINES:

The guidelines below are taken from manufacturer's guidelines of products used and the States guidelines.

1. When controls are out of shift, trend or range, the corrective action is as follows:
   - Repeat the test to verify technique or test strip or cuvette deterioration.
   - Check expiration date. Ensure correct timing was exact
   - Ensure the right quantity of specimen was used
   - Clean machine according to manufacturer's guidelines
   - Check controls and calibration material when the lab has double-checked and the repeat test is still out of range.
   - Notify supervisor. Call Service Representative. Use another machine. Use another Hgb/Glucose cuvette or test strip.
   - Do not run client's sample until at least one control is in standard deviation. If necessary, send specimen to Quest Diagnostics lab. Notify department head.

2. Instrument Failure

   In the event that the HemoCue (Hemoglobin/Glucose) instruments are out of order the lab will send these tests out to a reference lab. Please refer to the back of the "Equipment Maintenance log" book located in the lab for a complete listing of equipment listing and care or see LAB-29 Test Systems Backup Plans for In-house Labs Policy.

IV. REPORTING

1. Notify supervisor of equipment failure and call the service representative.

2. If specimen has to be sent out due to control deviation, notify the department head.

3. Abnormal test control values outside of lab reportable range are given to the appropriate department head for follow-up.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CHILD HEALTH PROGRAM

DATE DEVELOPED: 5/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 6/17; 6/18

I. POLICY:

The Division of Public Health laboratory staff will follow the Laboratory Technical Manual for procedures in collecting, testing, packaging, transporting or shipping specimens for Child Health Program clinical services. Laboratory services provided will be determined by the Child Health Program Guidelines and Policy. The nurse in the Child Health Program will determine the necessary lab work per program guidelines and policy. The nurse will order lab test via EHR to ensure the appropriate tests are performed. Test paper requisitions will be used for NCSLPH via EHR. In-house testing orders and Quest Diagnostics lab orders will be via EHR.

II. PURPOSE:

To ensure proper collection, testing, packaging, and shipping of lab specimens. To reduce the risk of error, to provide the best quality specimen for testing and provide accurate results.

III. GUIDELINES:

The guidelines below have been cross-referenced from the current contract addenda.

A. All Child Health Program clients who present for a well child check-up and/or physical should receive age appropriate laboratory services per program guidelines.

B. Laboratory testing may include, but are not limited to, the following:

- Hemoglobin
- Urinalysis (dipstick)
- Sickle Cell Testing
- Blood Lead Testing

C. If a Child Health client presents for a well child check-up or physical exam and has obvious signs or symptoms of illness (example: cough, fever,

diarrhea, etc.), their physical is deferred and rescheduled. The client is referred to their private provider for follow-up.

IV. REPORTING:

A. Values within normal range – (see D-4 below).

B. Abnormal values – are any values out of normal range but not within a panic value.

C. Panic values – are those values that are in the "high risk" area for immediate problems or life-threatening occurrences. Panic values are relayed verbally to the Child Health Coordinator or assigned nurse in the Coordinator's absence as soon as possible. The lab staff will enter who they verbally gave report to in the correct section in the EHR along with date, time, and initials.

D. Lab reports/test results –

1. Laboratory staff should log in all reports completed by in-house, state laboratory, or contracting laboratories. In-house lab results will be put into the electronic health record.

2. Laboratory staff should mark an asterisk (*) beside any abnormal values from the State Lab.

3. Panic values should be reported verbally to the Child Health Program Coordinator (or nurse assigned to Child Health for the day in the Coordinator's absence) for appropriate follow-up. The lab staff will enter who they verbally gave report to in the correct section in the EHR along with date, time, and initials.

4. Laboratory staff should give all lab reports/test results via EHR (except as described below) to the appropriate Advanced Practice Provider (APP) (or the nurse assigned for the day to the program) for appropriate follow-up. Quest Diagnostics lab results will be sent via EHR to appropriate APP.

5. All Sickle Cell and Lead Level reports will be placed in a folder in the lab and the Child Health Nurse designated to follow the program will assess the reports and provide follow-up per program policy and guidelines. Any abnormal lab results will be marked with an asterisk (*) beside each abnormal lab.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TUBERCULOSIS CONTROL PROGRAM

DATE DEVELOPED: 9/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 6/17

I. POLICY:

The Division of Public Health laboratory staff will follow the Laboratory Technical Manual for procedures in collecting, testing, packing, transporting or shipping specimens for the Tuberculosis (TB) Control Program. Laboratory services provided will be determined by the (TB) Tuberculosis Control Program guidelines and policy. The agency TB Program Coordinator (nurse) will determine and prepare the necessary lab requisitions to ensure the appropriate tests are performed.

II. PURPOSE:

To ensure proper collection, testing, packaging, and shipping of lab specimens. To reduce the risk of error, provide the best quality specimen for testing and provide accurate results.

III. GUIDELINES:

A. All tuberculosis related clients are provided laboratory tests as recommended by the NC TB Policy Manual which includes, but is not limited to:

1. Liver function test panel as indicated.

2. HIV test

3. Bacteriology tests, for the presence of mycobacteria.

IV. REPORTING:

A. Values within normal range (see E-4 below).

B. Abnormal values are values out of normal range but not within a panic value - normal range being defined by the laboratory conducting test and/or agency policy.

C. Elevated or low values (outside normal range) for the NCSLPH should be marked with an asterisk (*) beside the abnormal result and the report given to the TB Program Coordinator nurse for program appropriate follow-up.

D. Panic values are those values that are in the "high risk" area for immediate problems or life-threatening occurrences. Panic values are relayed verbally to the TB Program Coordinator nurse as soon as possible and entered into the electronic health record (EHR) to whom the lab tech verbally reported to.

E. Lab reports/test results

1. Laboratory staff will log in all reports completed by in-house, state laboratory, or contracting laboratories. In-house lab results will be put into the EHR.

2. Lab staff will mark an asterisk (*) beside any abnormal values from the State.

3. Panic values will be reported verbally to the TB Program Coordinator nurse and entered into the EHR in the correct section who the lab tech reported to, time, date, and initials. In the absence of the TB Program Coordinator the Communicable Disease Supervisor should be notified.

4. Laboratory staff will give all lab reports/test results to the TB Program Coordinator nurse for appropriate follow-up via EHR.

5. In the absence of the TB Program Coordinator nurse reports will be given to the Communicable Disease Supervisor.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: FAMILY PLANNING LABORATORY POLICY

DATE DEVELOPED: 8/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 6/15; 6/16; 6/17

I. POLICY:

The Division of Public Health Laboratory staff will follow the Laboratory Technical Manual for procedures in collecting, handling, testing, packaging, transporting, or shipping specimens for Family Planning Clinical services. Family Planning Program Guidelines and Policy will determine laboratory services provided. The Advanced Practice Provider (APP) or program nurse will determine and prepare the necessary lab slips /orders for the laboratory staff to ensure appropriate test are preformed.

II. PURPOSE:

To ensure proper collections, handling, testing, packaging and shipping of lab specimens. To reduce the risks of error, provide the best quality specimen for testing and provide accurate results. .

III. GUIDELINES:

The guidelines below are cross-referenced from the current Contract Addenda.

A. Family Planning laboratory tests/specimens for initial and annual physicals for females (Title X services) include any of the following labs:

1. Initial Visit:
   - Hemoglobin
   - Vaginal wet mount
   - Blood Glucose
   - Lipid panel
   - Syphilis serology
   - Urine dip check with chemical test strips
   - Urinalysis (with micro)
   - HIV test
   - Pap Test
   - Pregnancy test
   - Fecal occult blood
   - Chlamydia/Gonorrhea Probe

2. Annual/Return Visits:

- Hemoglobin
- Chlamydia/Gonorrhea Probe
- Vaginal Wet Mount
- Blood Glucose
- Lipid panel
- Syphilis serology
- Urine dip check with chemical test strip
- Urinalysis (with micro)
- HIV test
- Pap Test
- Pregnancy test
- Fecal occult blood

B. Family Planning laboratory tests/specimen for initials and annual physicals for males (Title X services) include any of the following labs:

1. Labs Initial Visit:

- Hemoglobin
- Gonorrhea culture
- Chlamydia
- Blood glucose
- Lipid panel
- Syphilis serology
- Urinalysis dip or micro
- HIV Testing
- Fecal occult blood

2. Labs Annual/Return Visit:

- Hemoglobin
- Gonorrhea culture
- Chlamydia
- Blood Glucose
- Lipid panel
- Syphilis Serology
- Urinalysis dip or micro
- HIV testing
- Fecal occult blood

IV. REPORTING:

A. Values within normal range (See D-4 below).

B. Abnormal values are any values out of normal range but not within a panic value.

C. Panic values – are these values that are in the "high risk" area for immediate problems or life threatening occurrences. Panic values are relayed verbally to the APP as soon as possible. The panic value is entered into the EHR and who the lab tech reported to, time, date and initials.

D. Lab Reports/Test Results -

1. Laboratory staff will log in all reports completed by in-house, state laboratory or contracting laboratories. In-house lab results will be put into the electronic health record.

2. Lab staff will put an asterisk mark (*) beside any abnormal values from the State Lab or any contracting labs.

3. Panic values will be reported verbally to the APP (or program nurse if APP is unavailable) and entered into the EHR in the correct sect to whom the lab tech reported to, time, date, and initials.

4. Laboratory staff will give all lab reports / test results to the appropriate APP or program nurse for appropriated follow-up. If pap results required additional testing for HPV, the lab personnel will pull charge sheet and attach it to the lab pap results.

5. In the absence of the APP or program nurse reports will be given to the Clinical Nursing Supervisor.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: GONORRHEA CULTURES/INCUBATION TIMES

DATE DEVELOPED: 8/25/98
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 2/16; 6/16; 6/17; 6/18

I. POLICY:

The Division of Public Health laboratory staff will follow the Laboratory Technical Manual Guidelines for preparing, incubating and reading Gonorrhea Cultures.

II. PURPOSE:

To ensure proper procedures are followed in the handling of Gonorrhea Cultures to reduce the risk of error, to provide the best quality specimen, and to deliver accurate results.

III. GUIDELINES:

A. After twenty-four (24) hour incubation, examine Gonorrhea Culture (GC) plates for visible growth. If sufficient growth is visible, a presumptive diagnosis work-up may be done and results recorded in the GC Log book. If no growth is visible, incubation should continue for another twenty-four (24) hours. GC plates should be read at forty-eight (48) hours and a presumptive diagnosis work-up done and recorded in the GC Log book and preprinted electronic health record (EHR) order sheet. In-house test results will be put in the electronic health record. If there is any growth on the GC cultures, then they should be sent out to the SLPH for further testing and the urethral cultures should be tested in-house as well. This will be entered into the EHR as "Sent to the NCSLPH for Confirmation".

B. Thursday Clinic - Gonorrhea Culture (GC) plates are streaked and incubated as indicated in the Laboratory Technical Manual. GC plates are observed on Friday; if no growth, they continue with incubation for 48 hours more and are examined at 72 hours on Sunday. If results cannot be read by 72 hours the cultures should be disposed of and recollected from patient. Results are recorded in the GC Log book, lab preprinted requisition, put in the EHR, and.

C. Friday Clinic - Gonorrhea Culture (GC) plates are streaked and incubated as indicated in the Laboratory Technical Manual. They are incubated for forty-eight (48) hours and are examined on Sunday. Results are recorded in the GC Log book, lab preprinted requisition, put in the EHR, and saved.

D. Culture Plate Sterility – When new shipments of culture plates arrive from the supplier, they are stored in the laboratory refrigerator with the latest shipment stored in the back. Take one plate from each new lot number and place in incubator for sterility checks right away. At seventy-two (72) hours, one plate from each lot number is examined visually for any growth. Culture plates should have no growth. If any growth is present, the entire lot number of plates is labeled "Do Not Use" and laboratory staff will notify the supplier for return instructions and replacement. Results are recorded in the GC Log book.

E. When disposing of all used culture plates, soak for 10-15 minutes in 10% bleach solution that is mixed daily then throw out culture plates in regular trash. Pour solution out at end of work day.

IV. REPORTING:

A. Laboratory staff will record Gonorrhea Culture results on the preprinted EHR order in the EHR, save and close. Report results in the GC Log book.

B. Laboratory staff will give Gonorrhea Culture report results in the EHR to the ordering Advanced Practice Provider (APP) or program nurse for follow-up.

C. In the absence of the APP or program nurse, reports will be given to the Clinical Nursing Supervisor.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PEDIATRIC PRIMARY CARE – LAB

DATE DEVELOPED: 5/93
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 2/16; 6/17; 6/18

I. POLICY:

The Division of Public Health laboratory staff will follow the Laboratory Technical Manual for procedures in collecting, testing, packaging, transporting or shipping specimens for Pediatric Primary clinical services. Laboratory services provided will be determined by Pediatric Primary Care Program Guidelines and Policy. The Advanced Practice Provider (APP) will determine and prepare the necessary lab requisitions to ensure the appropriate tests are performed.

II. PURPOSE:

To ensure proper collection, testing, packaging, and shipping of lab specimens. To reduce the risk of error, to provide the best quality specimen for testing and provide accurate results.

III. GUIDELINES:

The guidelines below have been cross-referenced from the current contract addenda.

A. All Pediatric Primary Care clients who present for well child check-up and physicals should receive age appropriate laboratory services per program guidelines.

B. Laboratory testing may include, but are not limited to, the following:

- Hemoglobin
- Urinalysis (dipstick)
- Sickle Cell Testing
- Blood Lead Testing

C. All Pediatric Primary Care clients who present for sick visits should receive appropriate diagnosis related lab work as ordered by the APP. Laboratory testing may include, but are not limited to, the following:

- CBC
- Sed Rate
- Mono
- Electrolytes

- Strep Screening
- Nasal Culture
- Eye Culture and Sensitivity
- Stool Culture for Rota Virus, Bacteria, and/or Parasites
- Urine Culture and Sensitivity

IV. REPORTING:

A. Values within normal range – (see D-4 below).

B. Abnormal Values – are any values out of normal range but not within a panic value.

C. Panic values – are those values that are in the "high risk" area for immediate problems or life-threatening occurrences. Panic values are relayed verbally to the Physician Extender as soon as possible and entered into the electronic health record (EHR) along with who lab tech reported to, time and date, and initials.

D. Lab reports/test results –

1. Laboratory staff will log in all reports completed by in-house, state laboratory, or contracting laboratories. In-house lab results will be put into the electronic health record. Quest Diagnostics lab reports will be sent to the ordering provider and saved.

2. Laboratory staff will put an asterisk mark (*) beside any abnormal values from the state lab.

3. Panic values will be reported verbally to the Physician Extender or program nurse if the Physician Extender is unavailable and entered into the EHR, with who lab tech reported to, time and date, and initials.

4. Laboratory staff will give all laboratory reports/test results to the appropriate Physician Extender or program nurse for appropriate follow-up by EHR, requisitioned reports or via NCSLPH.

5. In the absence of the Physician Extender or program nurse, reports will be given to the Clinical Nursing Supervisor.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ADULT PRIMARY CARE

DATE DEVELOPED: 1999
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 6/15; 2/16; 6/16; 6/17; 6/18

I. POLICY:

The Division of Public Health laboratory staff will follow the Laboratory Technical Manual for procedures in collecting, testing, packaging, transporting or shipping specimens for the Adult Primary Care Program. Laboratory services provided will be determined by the Advanced Practice Provider (APP) and will follow the Adult Primary Care guidelines and policy. The APP or program nurse will prepare the necessary lab requisitions for the laboratory staff to ensure appropriate tests are performed.

II. PURPOSE:

To ensure proper collection, handling, testing, packaging and shipping of lab specimens. To reduce the risk of error, provide the best quality specimen for testing, and provide accurate test results.

III. GUIDELINES:

A. All Adult Primary Care clients who present for an initial or annual visit will receive age, history, or clinically indicated appropriate laboratory testing as determined by the APP. Possible tests may include the following:

Females	Males
Pap Test	Fecal occult blood
Wet Mount	Hemoglobin
Fecal occult blood	Blood Glucose
Hemoglobin	Lipid panel
Blood Glucose	Urinalysis
Lipid panel	
Urinalysis	

B. All Adult Primary Care clients who present for sick or symptomatic visits will receive diagnosis related lab work including labs mentioned above (but not limited to) and any of the following as ordered by the APP:

- Arthritis Profile
- B-12 Level

- Folic Acid
- Drug Levels
- Executive Profile
- Hormone Levels
- CO_2
- HIV Test
- Thyroid Panel
- CBC
- STD Screening (Gonorrhea Culture, Chlamydia, Syphilis Serology, or Herpes Culture)

C. Other pap tests may be done in response to directives or recommendations from lab (performing test), Medical Consultants, Dysplasia Clinic Guidelines, or state guidelines.

D. Adult Primary Care clients in for routine follow-up will receive diagnosis related laboratory monitoring as ordered by the APP using Adult Primary Care guidelines and policies.

IV. REPORTING:

A. Values with-in normal range - (see D-4 below).

B. Abnormal values – any values out of normal range but not within a panic value.

C. Panic values – those values that are in the "high risk" area for immediate problems or life-threatening occurrences. Panic values are relayed verbally to the APP as soon as possible and entered into the electronic health record (EHR) along with who lab tech reported to, time and date, and initials.

D. Lab Reports/Test Results -

1. Laboratory staff will log in all reports completed by In-house, state laboratory, or contracting laboratories. In-house lab results will be put in the electronic health record. Quest Diagnostics lab reports will be sent to the ordering provider via EHR and saved.

2. Lab staff will put an asterisk mark (*) beside any abnormal values from the State Lab.

3. Panic values will be reported verbally to the APP or program nurse if APP is unavailable and entered into the EHR along with who lab tech reported to, time and date, and initials.

4. Laboratory staff will give all lab reports/test results to the appropriate APP or program nurse for appropriate follow-up. If pap results required additional testing for HPV, the lab personnel will pull charge sheet and attach it to the lab pap results.

5. In the absence of the APP or program nurse reports will be given to the Clinical Nursing Supervisor.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: LABORATORY POLICY FOR GLUCOSE SCREENING TEST FOR DIABETES

DATE DEVELOPED:
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 2/16; 6/17; 6/18

I. POLICY:

The Division of Public Health Laboratory staff will follow the Laboratory Technical Manual for procedures in collecting, handling and testing serum and capillary glucose lab specimens for programmatic clinical services. Laboratory services provided will be determined by each program guidelines and/or Advanced Practice Provider (APP) orders. The APP or Program Nurse will prepare the necessary lab requisition for the laboratory staff to ensure appropriate tests are performed.

II. PURPOSE:

To ensure proper collection, testing, packing of serum and/or capillary glucose lab specimens. To reduce the risk of error, provide the best quality specimen for testing and provide accurate test results.

III. GUIDELINES:

A. Clients should not have consumed food or beverage, other that water for at least 8 hours, before the blood sample is collected.

B. Serum Glucose

1. Measurement of fasting serum glucose is the principal and most accurate method of screening in non-pregnant, asymptomatic adults.

   * A fasting serum glucose level above the normal range for the current contract lab is considered elevated.

2. If a fasting sample is not available, random blood glucose levels can be used in screening.

   * A random blood glucose level in excess of 200 mg/dl should be considered elevated.

C. Capillary Blood Glucose

* Fasting > 106 mg/dl is considered to be elevated.
* 2 hr PP$\geq$ 140 mg/dl is considered to be elevated
* If a fasting sample is not available, random blood glucose levels can also be used in screening for DM.

* A random blood glucose level in excess of 200 mg/dl is considered elevated and an indicator of further assessment.
* If the fasting reading is between>106 mg/dl and ≤ 120 mg/dl the client should return the next clinic day and have a 2 hour postprandial blood glucose screening.
* If the fasting blood glucose is between 8-<12 hours since last p.o. intake, and is below 65mg/dl, a retest after a 12-hour fasting should be done.
* Notify APP or Program Nurse STAT if blood glucose level is ≤ 60. Client should be treated per Agency hypoglycemia Policy/Standing Orders. The lab tech should record in the EHR who, time and date, and when results was verbally reported along with initials.

D. Urine Test of Ketones

* If blood glucose level is ≥ 240 mg/dl a dipstick urine test to check for Ketones should be performed, as ordered by the APP.

IV. REPORTING

A. Values within normal range (see D-4 below)

B. Abnormal values – are any values out of normal range but not within a panic value.

C. Panic value - are those values that are in the "high risk" area for immediate problems or life-threatening occurrence. Panic values are relayed verbally to the APP as soon as possible and entered into the EHR along with who lab tech reported to, time and date, and initials.

D. Lab Reports/Test Results -

1. Laboratory staff will log in all reports completed by in-house, state laboratory or contracting laboratories. In-house lab results will be put into the electronic health record. Quest Diagnostics lab reports will be sent to the ordering provider via EHR and saved.

2. Lab staff will put an asterisk mark (*) beside any abnormal values from the State Lab.

3. Panic values will be reported verbally to the APP or Program Nurse if APP is unavailable and entered into the EHR along with who lab tech reported to, time and date, and initials.

4. Laboratory staff will give all lab reports/test results to the appropriate APP or Program Nurse for appropriate follow-up.

5. In the absence of the APP or Program nurse reports will be given to the Clinical Nursing Supervisor.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: LABORATORY HYPOGLYCEMIA POLICY

DATE DEVELOPED: 1995
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 6/17

I. POLICY:

The Division of Public Health Laboratory staff will follow the Laboratory Technical Manual for procedures in collecting, handling and testing capillary blood samples for glucose testing. Glucose levels less than 60 mg/dl or clients who report symptoms of low blood glucose levels to laboratory staff, will be referred immediately to the program nurse or Advanced Practice Provider (APP) for treatment of hypoglycemia following the Agency's Standing Order for Hypoglycemia.

II. PURPOSE:

To ensure proper collections, handling and testing of in-house capillary blood specimens for Glucose testing. To reduce the risk or errors provide the best quality specimen and provide accurate test results. To reduce the risk of life threatening problems and aid early intervention and treatment.

III. GUIDELINES:

A. If the client is awake and alert and has symptoms of low blood glucose or has a blood glucose level of 60 mg/dl report immediately to the APP or Program Nurse for immediate treatment per Agency Standing orders on Hypoglycemia. The lab tech will record results in the electronic health record (EHR) along with who lab tech reported to, time and date, and initials.

B. If client is unconscious, call 911 and immediately (STAT) notify Physician Extender or Program Nurse.

IV. REPORTING

Log test results on laboratory requisition and in the electronic health record. Write client's name, date, and time on lab test log and put an "X" in the appropriate test area for glucose test.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CHOLESTEROL SCREENING TESTS

DATE DEVELOPED:
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 2/16; 6/18

I. POLICY:

The Division of Public Health Laboratory staff will follow the Laboratory Technical Manual for procedures in collecting, handling and testing venipuncture samples for cholesterol screenings. Laboratory services provided will be determined by each clinic programs guidelines, current contract addenda, and/or the Advanced Practice Provider (APP) diagnoses related orders. Program Nurse will prepare the necessary lab requisitions for laboratory staff, to ensure appropriate tests are performed.

II. PURPOSE:

To ensure proper collection, handling, and testing of cholesterol, blood samples. To reduce the risk of error, provide the best quality specimen for testing and to provide accurate test results.

III. GUIDELINES:

A. Screening Total Cholesterol Blood (lipid panels are drawn to assess cholesterol levels and sent to the outside lab) -

* Men – between the ages of 35-65 years of age
* Women – between 45-65 years of age

B. Screening for men younger than 35 year of age and women younger than 45 years of age is not recommended, unless the history, physical exam, or the client has at least 2 risk factors for CHD (i.e. diabetes, smoking, hypertension, obesity, family history of very high cholesterol, premature CHD in a first degree relative before age 50 in men or age 60 in women).

C. Client will be 20 years of age and above

D. Client will not be acutely ill, losing weight, pregnant or breastfeeding

E. Classification of Blood Cholesterol

- Below 100 mg/dl – repeat test
- Below 200 mg/dl – Desirable levels
- 200-239 mg/dl – Borderline High Blood Cholesterol
- 240 mg/dl or above – High Blood Cholesterol
- 240 mg/dl and above – repeat test as ordered by practitioners

IV. REPORTING

A. Values within normal range – (see D-4 below).

B. Abnormal values are any values out of normal range but not within a panic value.

C. Panic value – are these values that are in the "high risk" area for immediate problems or life-threatening occurrence. Panic values are relayed verbally to the APP as soon as possible and entered into the electronic health record (EHR) along with who lab tech reported to, time and date, and initials.

D. Lab Reports/Test results -

1. Laboratory staff will log in all reports completed by state laboratory or contracting laboratories.

2. Lab staff will put an asterisk mark (*) beside any abnormal values from the State Lab.

3. Panic values will be reported verbally to the APP or Program Nurse if APP is unavailable and entered into the EHR along with who lab tech reported to, time and date, and initials.

4. Laboratory staff will give all lab reports/test results to the appropriate APP or program nurse for appropriate follow-up. Quest Diagnostics lab reports will be sent to the ordering provider via EHR.

5. In the absence of the APP or program nurse reports will be given to the Clinical Nursing Supervisor.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: LABORATORY POLICY FOR WIC (WOMEN, INFANTS AND CHILDREN) PROGRAM

DATE DEVELOPED: 6/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18

I. POLICY:

The Division of Public Health Laboratory staff will follow the Laboratory Technical Manual for collecting, handling and testing in-house hemoglobin lab specimen for the WIC Program. The Nutritionist in the WIC program is authorized to request hemoglobin testing.

II. PURPOSE:

To ensure proper collection, handling and testing of in-house hemoglobin lab specimens. To reduce the risk of error, provide the best quality specimen for testing and provide accurate test results.

III. GUIDELINES:

The guidelines below are crossed referenced from the current contract addenda.

A. Hemoglobin test on women, infants (> 6 months old), and children applying for certification or recertification in the WIC Program.

1. Within normal limits range for hemoglobin are as follows:

Infants after neonatal	11.1 – 14.0 g/dl
Children 2 years – 13 years	gradually increase to adult normals
13 years & up:	
female	12.0 – 15.0 g/dl
male	13.0 – 17.0 g/dl

2. Repeat test for values less than 11.1 g/dl.

3. Record Hemoglobin results on lab requisitions form and give form to the WIC program nutritionist for program appropriate follow-up.

Hemoglobin follow-up to be performed as noted below:

i. Hemoglobin 10-12 g/dl is normal; follow up should occur per routine WIC protocol.

ii. Hemoglobin 9-10 g/dl;

(a) Advise caregiver/parent to start over the counter Poly-Vi-Sol with iron,
(b) Increase iron rich foods, and
(c) Decrease whole milk intake.
(d) Recheck finger stick hemoglobin in 1 month.
- Advise caregiver/parent to bring child back for hemoglobin test in 1 month.
- Make a notation in chart regarding all information, findings and recommendations.
- Give chart to triage nurse for follow up (to obtain an order for lab and complete the lab request form).

iii. Hemoglobin < 9 g/dl Schedule an appointment for child in Primary Care.

B. Calculate age, record on growth chart in the clinical record.

C. Weight, record results on growth chart in the clinical record.

D. Height/Length, record on growth chart in the clinical record.

IV. <u>REPORTING</u>:

1. Laboratory staff will record on log sheet number of hemoglobin tests that were done that day.

2. Hemoglobin results will be recorded on the requisition on the form and the forms given to Nutrition staff for WIC program appropriate follow-up

3. In the absence of the Nutritionist the reports will be given to the program supervisor.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: POWER OUTAGE

DATE DEVELOPED: 1/23/95
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The Division of Public Health Laboratory staff will follow the guidelines as set forth by equipment manual/manufacturers recommendations.

II. PURPOSE:

To ensure proper use or disposal of products that have been exposed to temperatures outside their recommended range for an extended period of time.

III. GUIDELINES:

1. In the event that the power is off for an extended period of time all products in the refrigerator and freezer will be discarded. Also, cultures in the incubator will be discarded and clients will be asked to return for a repeat test.

2. The supervisor will be notified if lab test can be collected and sent to a reference lab or if client should be rescheduled to return for lab test when power has returned.

3. Lab personnel will order new controls and supplies immediately.

IV. REPORTING

Power outage and alternative methods for obtaining lab test should be reported to the supervisor.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: RECORDS KEEPING SYSTEM

DATE DEVELOPED: 2/93
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 2/16; 6/16; 6/17; 6/18

I. POLICY:

The Division of Public Health laboratory staff will follow state and CLIA guidelines for receiving, distribution and retention of lab records.

II. PURPOSE:

To ensure all lab records are received, distributed, and retained in a manner that reduces the risk of error and assures the client of the most expeditious route of obtaining lab results.

III. GUIDELINES:

A. State lab work is received by courier or mail.

B. The Quest Diagnostics lab reports are sent via EHR to the ordering provider and saved.

C. All NC SLPH lab work is distributed to programs by lab staff, followed up by the program nurse, Advanced Practice Provider (APP) or client's medical provider, and then filed in the client's electronic health record.

D. The agency lab keeps the copy lab requisition for contracting laboratories. The lab requisition is then filed by the month and retained for 1 year in the lab, and for an additional year in off-site storage.

E. In-house preprinted EHR lab result orders are recorded on preprinted order forms. In-house lab results are put into the EHR and filed in client's EHR.

For the current year of laboratory reports, a copy is filed by month in the locked filing cabinet in Room 18. At the end of the fiscal year (January through December), the reports are pulled from the filing cabinet and stored in a file box in Room 18 for an additional year. During the second year of storage, the file box is transferred to the agency's off-site storage area. After 2 years of storage, the records are shredded or incinerated.

F. Laboratory logs stored for the current year are stored in the laboratory. They are reviewed by the NCSLPH Technical Consultant quarterly. After 2 years the logs can be shredded or incinerated.

G. Discontinued policies and procedures will be retained in a separate section of the manual or in lab files for a minimum of two years with the date of discontinuance noted.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SEXUALLY TRANSMITTED DISEASES (STDS)

DATE DEVELOPED: 1998
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 1/15; 2/16; 6/17; 6/18; 6/21

I. POLICY:

The Division of Public Health laboratory staff will follow the Laboratory Technical Manual for procedures in collecting, testing, packaging, transporting or shipping specimens for STD Program Clinical Services. Laboratory services provided will be determined by the STD Program Guidelines and Policy. The Physician Extender or program nurse will determine and prepare the necessary lab requisitions for the laboratory staff to ensure appropriate tests are performed.

II. PURPOSE:

To ensure proper collection, testing, packaging and shipping of lab specimens to reduce the risk or error, provide the best quality specimen for testing and provide accurate results.

III. GUIDELINES:

The guidelines below are cross-referenced from the current contract addenda.

A. The Advanced Practice Provider (APP) or STD Program Nurse will determine the necessary lab tests per Program Guidelines.

B. Confidential testing for HIV (pre and post counseling completed by trained nurse).

C. STD Laboratory testing for asymptomatic, symptomatic, or contacts may include:

1. For Women:

- HIV testing
- Gonorrhea Culture (Anal or Oropharyngeal)
- Vaginal Wet Mount (bacterial, yeast, trichomonas, or WBC's)
- Chlamydia/Gonorrhea Probe
- Herpes (genital)
- Syphilis

2. For Men:

- HIV testing
- Gonorrhea Smear (Urethral)
- Gonorrhea Culture (Urethral, Anal, or Oropharyngeal)
- Herpes (symptomatic)
- Syphilis
- Urine Naat Testing

IV. REPORTING:

A. Laboratory staff will log in all reports ordered in the EHR and preprint the order for lab records in-house. In-house lab results will be put into the electronic health record. Quest Diagnostics lab reports will be sent via EHR to the ordering provider and saved.

B. Laboratory staff will put an asterisk mark (*) beside any abnormal values from the State Lab.

C. Panic values will be reported verbally to the APP or program nurse if APP is unavailable and entered into the EHR along with who lab tech reported to, time and date, and initials.

D. Laboratory staff will give all lab reports/test results to the appropriate APP or program nurse for appropriate follow-up via EHR or NCSLPH reports.

E. In the absence of the APP or program nurse reports will be given to the Clinical Nursing Supervisor.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: BIOTERRORISM OR EMERGENCY LAB SPECIMENS

DATE DEVELOPED: 3/06
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The Division of Public Health lab staff will follow the SCOPE Manual for procedures in collecting, packing, transporting or shipping specimens of a Bioterrorism or Emergency nature as directed by NCSLPH. Labs may be sent to regional laboratories per NCSLPH guidelines when available.

II. PURPOSE:

The isolation, identification, confirmation, further studies of human disease-producing substances known to contain, or reasonably expected to contain, pathogens. Pathogens are identified as microorganisms (including bacteria, viruses, rickettsia, parasites, fungi) or recombinant micro-organisms (hybrid or mutant) that are known or reasonably expected to cause infectious disease in humans or animals.

III. GUIDELINES:

A. Specimens are defined and Risk Groups are categorized as RG1, RG2, RG3 and RG4; most will fall into RG2 or RG3.

- Risk Group 1 (RG1) are not subject to regulations, as they pose no risk to humans or animals.
- Risk Group (RG2) indicates pathogen is at lower risk of transmission from one infected person to another, the risk of the spread of infection is limited and effective treatments are available.
- Risk Group (RG3) indicates pathogen is at slightly higher risk of transmission from one infected person to another relative to RG2, the risk of infection is limited and effective treatments are available.
- Risk Group (RG4) indicates pathogen is at higher risk of transmission from one infected person to another relative to RG3, risk of infection is higher; therefore risk of transport is higher. Effective treatments may be limited or unavailable.

B. 1. Collect specimen following instructions in SCOPE Manual, using recommended collection kits.

2. Label each specimen tube, subculture, or smear with client's name, date of birth and your laboratory number if appropriate.

3. Fill out appropriate forms for specimen type.

4. Packaging of specimens:

   a. Inner packaging must meet all of the following requirements:

      - A water tight primary receptacle, with biohazard label
      - Watertight secondary packing, with name, address and telephone number of shipper on outside of secondary packaging
      - Primary receptacle or secondary packaging used for infectious substances must be capable of withstanding an internal pressure of 95 kPa and temperatures ranging from -40ºC to 55ºC
      - When the primary receptacle contains liquids, an absorbent material must be placed between the primary receptacle and the secondary packaging.
      - If multiple primary receptacles are placed in a single secondary packaging, they must be wrapped individually to ensure that contact between them is prevented.
      - The absorbent material must be sufficient to absorb the entire contents of all primary receptacles.
      - An itemized list of contents between the secondary packaging and outer packaging.

   b. Outer packaging highlights include the following requirements:

      - Must be of adequate strength for its capacity, mass and intended use.
      - Each package must be capable of passing the tests specified in Sec 178.609 of CFR.
      - Liquid of solid substances must have primary receptacles that have leak proof seals, such as adhesive tape when screw caps are used.
      - Ice of dry ice must be placed outside the secondary packaging.

- Interior supports must be provided to secure the secondary packaging in the originals position after the ice or dry ice has dissipated.
- If ice is used, packaging must be leak proof.
- If dry ice is used, the outer packaging must permit the release or carbon dioxide gas.

c. Outer labeling required approved "Infectious substance" label, and name of infectious substance given on dangerous goods bill must match exactly the name written on the outside of the packaging. In addition, the name, address and telephone number of shipper should be out outside of outer packaging.

C. For more information contact the NCSLPH at the following numbers:

- BT and Emerging Pathogens Main Line
  919-807-8765

- BT and Emerging Pathogens Duty Phone (24/7)
  919-807-8765

- BT and Emerging Pathogens Pager
  919-310-4243

- Epidemiology Main Line
  919-733-3419

/di

8.4

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

LABORATORY POLICY

TITLE: PHLEBOTOMY COMPETENCY PLAN

DATE DEVELOPED: 5/07
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

A Phlebotomy Coordinator (PC) or Co-Coordinators will be designated in each of the CLIA Contract County Local Health Department (LHD) Laboratories. The PC or Co-coordinators will manage the program in each local health department with the assistance of the Regional Laboratory Consultant.

II. PURPOSE:

To monitor all personnel who perform blood collection in the health departments, and if weaknesses are identified, provide training and oversight to improve skills and the quality of client services, minimize risks to clients and improve the quality of diagnostic blood specimens.

III. GUIDELINES:

1. There must be at least one designated individual to serve as the phlebotomy coordinator. Individual requirements include:

   - Documentation of a minimum of one-year phlebotomy experience
   - Successful demonstration of basic theoretical knowledge of phlebotomy through a written test provided by the SLPH
   - Attendance of scheduled continuing education sessions.

2. The Phlebotomy Coordinator(s) will maintain a current list of local health department personnel who perform blood collections. A schedule is kept to insure that all competency assessments for each employee are completed. This documentation will be maintained for 2 years.

3. All personnel assigned to perform client blood specimen collections must read the procedure and policy manuals addressing these collection techniques. The venipuncture and/or capillary puncture (finger and heel stick) procedure manuals must be reviewed by all phlebotomists annually and whenever it is updated or revised. Each employee must sign and date the review page after they have completed their review.

4. A competency skills checklist is used for direct observation. When narratives are necessary, they must be documented using memorandums.

5. Competency Assessment (CA) for phlebotomy (venipuncture and capillary puncture) must be integrated into the initial orientation process for newly hired personnel who will be assigned to perform blood specimen collections.

   The phlebotomy coordinator(s) should work closely with the first line supervisor(s) of the new employee(s) to document training and competency assessment. New personnel will need to be assessed during the initial orientation period prior to being assigned to perform blood collections and then re-assessed after 6 months of the assignment. If there are performance problem issues, then earlier re-assessment may be necessary to develop re-training plans. Local health department employees who are newly assigned to blood collection duties must also be assessed before they are permitted to collect client specimens and will be monitored the same as a new employee.

6. Personnel who perform phlebotomy as part of their regularly assigned duties will be subject to competency assessment on an annual basis. The Phlebotomy Coordinator and the first line supervisor will maintain documentation of competency assessment.

7. In the event of co-coordinators, they shall monitor each other and complete the competency assessment which will be maintained in the lab and reviewed by the Regional State Lab Consultant.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

LABORATORY POLICY

TITLE: TEST SYSTEMS BACK-UP PLANS FOR IN-HOUSE LABS

DATE DEVELOPED: 10/10
REVIEWED: 6/18; 6/19; 6/20; 6/21; 6/22; 10/22; 6/23; 8/23; 6/24
REVISED: 6/16; 6/17; 6/18; 6/22; 10/22; 8/23

I. POLICY:

The Division of Public Health Laboratory staff will follow the Laboratory Technical Manual for failure of in-house lab testing.

II. PURPOSE:

To ensure all in-house lab specimens are processed correctly, reduce the risk of error and provide accurate results.

III. GUIDELINES:

A. Glucose

1. Current Method-HemoCue 201
2. Back-up Plan
   a. Control problem – send specimen to Quest Diagnostics
   b. Instrumental problem – use another HemoCue 201 machine and send the broken analyzer to be serviced while using the back-up machine.
3. Clinic Notification: AH/FP/CH

B. Urine Dipstick

1. Current Method – Clinitek Status + Analyzer Multistix 10 SG
2. Back-up Plan - Multi-stix 10, manual dipstick
3. Clinic Notification: AH/FP/CH/STD

C. Urine Pregnancy (hCG)

1. Current Method – True® 20 pregnancy Stanbio Manufacturer
2. Back-up Plan
   a. Try to borrow test kit from nearby health department or send specimen to Quest Diagnostics.

b. Can store urine per manufacturer's instructions.

3. Clinic Notification: AH/FP/STD/CH

D. Vaginal Wet Mount

1. Current Method – microscope exam

2. Back-up Plan

a. Use alternate microscope within the lab.
b. If alternate microscope is not available, there is not an acceptable alternate method unless specimen can be read within 30 minutes of collection.

3. Clinic Notification: AH/FP/CH/STD

E. Urine Microscopy

1. Current Method – Bio-Rad, Urinalysis Control; microscope exam

2. Back-up Plan

a. Use alternate microscope within the lab.
b. If there is not a microscope available, send urine to Quest Diagnostics.
c. Centrifuge problem – Call Tracy Shives (336-306-4302) or call PSS (1-800-874-2240) for services or to obtain a loaner.

3. Clinic Notification: AH/FP/CH/STD

F. GC Smear-Culture

1. Current Method – Presumptive ID using GC-Lect media; oxidase and gram stain growth

2. Back-up Plan

a. Control or equipment/incubator problem – send specimens (GC plates) to Annie Penn Hospital (call APH lab first).
b. Media Problem – try to borrow media from nearby hospital or health department.
c. Clinic Notification: AH/FP/STD

G. Stat Male Smear

1. Current Method – microscope exam or gram stained exudate

2. Back-up Plan - perform routine GC culture

3. Clinic Notification: AH/FP/STD

H. Hemoglobin

1. Current Method – Hemocue 301
2. Back-up Plan
   a. Control problem – send specimen to Quest Diagnostics or reschedule the test.
   b. Instrument problem – use WIC analyzer as main lab back up. Request loaner instrument from Hemocue while primary analyzer is serviced.
3. Clinic Notification: AH/FP/CH/STD

I. Group A Streptococcus

1. Current Method – OSOM by Sekisui Diagnostics
2. Back-up Plan – submit specimen for throat culture to Quest Diagnostics.
3. Clinic Notification: AH/FP/CH

J. Fecal Occult Blood

1. Current Method – Hemoccult cards by Stanbio manufacturer
2. Back-up Plan – Store prepared slides per manufacturer's protocol (can store up to 12 days at room temperature prior to development) until testing is resumed. Developer can be used until expiration date.
3. Clinic Notification: AH/FP/CH

K. Rapid COVID

1. **Current Method – Status COVID-19/Flu A & B**
2. Back-up Plan – PCR test to Quest or NCSLPH

L. Rapid Flu

1. Current Method – **Status COVID-19/Flu A & B**
2. Back-up Plan – Rapid flu test, sent to Quest Diagnostics

M. Hemoglobin A1C (HbA1c)

1. Current Method – DCA Advantage Analyzer
2. Back-up Plan – Submit blood specimen to Quest Diagnostics

IV. REPORTING:

If any of the above occurs, please notify the Lab Manager or laboratory personnel.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: LABORATORY COMPETENCY ASSESSMENT

DATE DEVELOPED: 3/11
REVIEWED: 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/15

I. POLICY:

The Division of Public Health will provide laboratory competency assessments for its lab staff/personnel.

II. PURPOSE:

To describe the process of assessing laboratory testing personnel competence in order to be compliant with CLIA regulations and the terms of the North Carolina State Laboratory of Public Health (NCSLPH) CLIA Contract Program.

III. GUIDELINES:

A. The Division of Public Health participates in the NC CLIA Contract Program of which the Competency Assessment Program is a component.

B. Competency assessment encompasses the following:

1. Direct observation of all phases of testing.
2. Monitoring of recording and reporting processes.
3. Review of intermediate test results or worksheets, QC records, PT records, and preventive maintenance records.
4. Direct observation of instrument maintenance and function checks.
5. Assessment of test performance through previously analyzed specimens, blind samples, and external PT.

C. The Competency Assessment Program conducted by the NC CLIA Contract Program is a computer-based program that encompasses both live and photographed samples.

D. Two Competency Assessment sets are distributed two times each calendar year. The sets are:

1. Microscopy: Wet Mount, Urine Microscopy, Gonorrhea Smear and Syphilis Serology;

2. Microbiology: Gonorrhea Culture

E. The Division of Public Health laboratory participates in the following:

1. Microscopy
   - Wet Mount
   - CG Smear
   - Urine Microscopy

2. Microbiology
   - GC Culture

F. Testing personnel must maintain overall successful performance. Failure to do so indicates the need for retraining or other follow-up as established by the Technical Consultant.

G. Testing personnel who repeatedly fail to perform critical tasks will be removed from testing for that particular test.

IV. PROCESS:

A. Testing

1. The Laboratory Manager will receive an email from the Laboratory Improvement Unit of the North Carolina State Laboratory of Public Health with the link to the Quia quiz(zes) for the Competency Assessment (CA) set.

   a. The Microscopy set includes photos within the quiz. There are two unknowns for wet mount, two for urine microscopy and one for stat male smear. Answers can be selected in the quiz as photos are observed.
   b. The Microbiology set requires lyophilized samples that are mailed by LI. Testing personnel will process the samples according to the instructions and perform the appropriate test(s) using a patient requisition and/or worksheet, the same as used in patient testing. Results will be recorded in the Quia quiz.

2. The Laboratory Manger will forward the email to all testing personnel required to participate in the Competency Assessment Set.

B. Submitting Results

1. Each individual will enter his/her results into the Quia quiz which is accessed using the link in the forwarded email. Directions should be followed carefully.

2. Entries should be reviewed for accuracy and then printed following the instructions included within the quiz.

3. Press the SUBMIT button to transmit the results to the LI Unit. The SUBMIT button must be pressed for the results to be transmitted. Print the page that reads, "Thank you, your results have been submitted". Any results not received by the due date will be marked as incorrect.

4. The tester must sign the quiz/attestation statement.

5. Testing personnel will give the Laboratory Manager the printed results and attestation statement as evidence of having completed the Competency Assessment Set.

C. Evaluation

1. Results will be tabulated by the LI Unit and forwarded to the Technical Consultant for review.

2. The Technical Consultant will generate a Results Summary Report for each county laboratory and email the report to the Laboratory Manager and will include the following:

   a. Answer key for the quiz.
   b. Summary of correct results for the contract area.
   c. Indicate for each participant "Pass" or "Fail" for each test analyte.
   d. Indicate if a reassessment is necessary.

3. The Laboratory Manager will print, review, and sign the report.

4. The Laboratory Manager will review the results with each tester. The tester will sign the summary report.

5. Documentation of results and review of results should be filed with competency assessment records and kept for a minimum of two years.

D. Follow UP

The Technical Consultant is responsible for determining the type of follow up necessary for a CA failure. The primary option is to assign a reassessment set for the corresponding failed test(s). Based on submitted results, the Technical Consultant may require a reassessment set for an individual even if a set is passed.

1. The LI Unit will send an email to the Laboratory Manager with the link to the Quia quiz(zes) for the Competency Reassessment Set.
2. The Laboratory Manager will forward the email to all testing personnel required to participate in the Competency Reassessment Set.
3. Testing will be performed and results entered and submitted following the steps in Submitting Results.
4. No further action is required if testing personnel successfully pass the reassessment.
5. Unsuccessful reassessment performance and any further corrective actions will be communicated to the Laboratory Manager by the Technical Consultant.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: LABORATORY PROFICIENCY TESTING

DATE DEVELOPED: 3/11
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/15

I. POLICY:

The Division of Public Health will provide Laboratory Proficiency Testing to laboratory staff/personnel to ensure the accuracy of lab results obtained.

II. PURPOSE:

To describe the proficiency testing (PT) process which assesses the ability of the laboratory to report accurate results. Proficiency testing is a requirement of CLIA '88 and the North Carolina State Laboratory of Public Health (NCSLPH) CLIA Contract Program.

III. GUIDELINES:

A. Proficiency testing is required for each non-waived test performed under a CLIA certificate. As a participant in the NCSLPH CLIA Contract Program, proficiency testing may or may not be performed on-site.

B. PT Modules required for Area B:

1. GC Cultures
2. Gram Stain
3. PPMP (urine microscopic exam, vaginal wet mount exam)
4. Waived glucose/hemoglobin
5. Syphilis Serology

IV. PROCESS:

A. Selection

1. The Technical Consultant determines which laboratories will perform testing for the Area B CLIA certificate. This is determined by local test menu, staffing, and previous history of PT.

2. The Technical Consultant will select the possible PT sites (counties) in September/October of the year prior to testing. The Technical Consultant will confer with the county's lab manager to decide if performing PT is appropriate for those sites.

3. When the testing sites are finalized, the PT subscription and fees are submitted by the NCSLPH.

B. Documentation

1. The Technical Consultant will provide a Proficiency Testing statement each year that will include the names and PT identification numbers of the counties performing PT for the Area B.

2. The statement should be signed by the Technical Consultant and the lab manager and filed with quality assessment documents for a minimum of two years.

C. Testing

1. If Rockingham County is selected to perform testing, the Technical Consultant will provide the following items:

   a. Instructions for counties performing Proficiency Testing;
   b. Proficiency Testing Performance;
   c. PT Missed Analyte Investigation.

2. The PT provider will supply a shipping schedule and a three-ring binder to store PT documents.

3. Test modules will have three shipping dates and specific deadlines for submitting results.

4. Testing **must** be rotated among staff and be performed independently.

5. PT samples will be handled in the same manner as patient samples.

6. The Technical Consultant must review results before they are submitted. See Instructions for Counties Performing Proficiency Testing (PT) for more details.

D. Evaluation

1. Graded results from the PT provider will be received by the lab manager and the Technical Consultant.

2. The lab manager will review, sign and date the results.

3. The lab manager is responsible for completing the Proficiency Testing Performance form for each PT module.

4. The Technical Consultant is responsible for follow up of any unsatisfactory results and unsuccessful performances.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ELECTRONIC HEALTH RECORD – ORDERING AND RESULTING LABORATORY TESTS

DATE DEVELOPED: 4/15
REVIEWED: 6/17; 12/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 12/17; 6/18

I. POLICY:

The Rockingham County Division of Public Health Services' electronic health record (EHR) was developed by Patagonia Health to allow for electronic reporting of all laboratory tests performed at the Division of Public Health. The system also allows for direct interface of tests performed at reference laboratories.

In accordance with HIPAA, access to EHR patient information is limited to those individuals having a need of this information for patient care. Users of this system include medical providers, laboratory technologists, management support, finance, WIC, and clinical staff.

III. GUIDELINES:

A. Laboratory Orders:

1. Laboratory orders (in-house and reference) will be sent to the laboratory EHR.

   - Only in-house laboratory tests will be resulted in the EHR.
   - Reference laboratory results will be scanned or available by direct interface with the reference laboratory. (Refer to Reference Laboratory Policy.)

2. In the EHR select patient from Today's Appointments.
3. Click on the Electronic Laboratory Results icon (beaker icon on lower left of the monitor).

Alternative Method for Laboratory Orders:

1. Authorized clinic staff and/or medical provider orders laboratory tests in the Assessment and Plan widget.
2. Provider will save and confirm order in summary window.
3. Provider will then assign to laboratory tech.
4. Laboratory tech will pick up order from their dashboard in Pending Encounters.

5. Laboratory tech will click on the Summary icon at the end of the row to review the order sent from the provider to confirm which test should be completed.
6. Once confirmed, laboratory tech will select Edit at bottom of summary window.
7. The patient chart will open.

B. Result Entry (In-House Test):

1. Locate the Laboratory Results widget on the dashboard and select the New In-House Result Adult button.
2. The laboratory requisition form will open for the laboratory tech to document test results, their initials, date and time for each test ordered.

    a. Click on the Date/Time/Read By box
        - Select the Now button and time and date will auto populate. Alternatively, the time and date can be entered by sliding the hour and minute buttons on the pen Date/Time/Read By box.
        - Click Done.
        - Repeat for each test performed.

    b. Document results on preprinted paper requisition form from EHR.
        - A copy of the paper requisition form is kept in the laboratory for a minimum of 2 years as a backup for result documentation.

3. Click Save Results button. A highlighted confirmation message will display “Saved Laboratory Results Successfully”.
4. Select the Close button.
5. Select Dashboard. Repeat above steps for each patient.
6. Return to Electronic Laboratory Results widget. Select desired patient.
7. Send the test result back to the provider by selecting the appropriate provider name in the Assign To box.
8. Click Save.

C. Edit Results

To document additional tests or to edit current test(s) that has not been signed by the provider:

1. Open the patient chart.
2. Select Electronic Laboratory Results icon.
3. In the Laboratory widget, click on today’s date.

4. Results entered for patient opens, scroll to the bottom.
5. Select Edit.
6. The In-House Requisition will open. Document results for the additional, missing, or changes to tests.
7. Click on the Date/time/Read by box.

   - Select the Now button and time and date will auto populate.
   - Click Done.

8. Click Save Results button. A highlighted confirmation message will display "Save Laboratory Results Successfully".
9. Select the Close button.
10. Select Dashboard. Repeat steps for each patient.
11. Return to Electronic Laboratory Results widget. Select desired patient.
12. Send the result back to the provider by selecting the appropriate provider in the Assign To box.
13. Click Save.

D. Printing Results

1. Open the patient's chart
2. Select Electronic Lab Results icon
3. In the Laboratory widget, click on today's date.
4. Results entered for the patient opens.
5. Scroll up to just above lab result and look for the "Print Lab Results" tab and click on it.

E. Add on Lab Test

1. Providers have the option to add on lab test after the patient's date of service per Quest Guidelines.
2. Provider must inform lab personnel which test to add within the specific time requirements per reference lab.
3. Lab personnel will call reference lab to verify that the test can be added. Or if HPV is to be added, lab will fax the "Test to be added" form to the reference lab after it is completely filled out or the lab will call Quest Diagnostics and add on test. (This form is in the Quest Diagnostics' folder on the shelf located in the main lab.)
4. Lab personnel will pull "Lab Charge Sheet" and take to billing with the new test codes to generate a new ESB.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ELECTRONIC HEALTH RECORD – RESULTS REVIEW

DATE DEVELOPED: 4/15
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

The Rockingham County Division of Public Health Services' electronic health record (EHR) was developed by Patagonia Health to allow for electronic reporting of all laboratory tests performed at the Division of Public Health. A mechanism must be established by the laboratory to ensure accurate results are being reported to the provider.

II. GUIDELINES:

1. Results documented on the preprinted EHR paper order requisition are considered the definitive result and EHR entry serves as a backup to the paper copy.

2. The Laboratory Manager or designee will confirm all paper entries with EHR backup daily review daily.

3. The reviewer will mark a check "✓" to the copy of the preprinted EHR paper order requisition.

4. In the event an error is detected the laboratory will correct and document error entries (Refer to Error Results Policy).

5. All requisitions will be kept a minimum of two (2) years.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ELECTRONIC HEALTH RECORD – COMPUTER DOWNTIME

DATE DEVELOPED: 4/15
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

When possible, computer downtime is scheduled to minimize interruption of patient care services. In the event an unscheduled downtime occurs, a system is needed to ensure uninterrupted laboratory services.

II. GUIDELINES:

1. Clinic staff will continue to fill out laboratory requisitions.

2. Requisitions will be brought to the laboratory.

3. Laboratory staff will perform testing as indicated on the requisition.

4. All results will be recorded on the laboratory requisition and a copy will be given to the clinic.

5. Once the electronic health record (EHR) is operational, all downtime laboratory requisitions will be entered into the computer.

6. If the downtime is for an extended time (greater than 24 hours) it will be at the discretion of the provider to determine if results should be entered into the EHR or scanned.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ELECTRONIC HEALTH RECORD – CORRECTED REPORTS

DATE DEVELOPED: 4/15
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

The Rockingham County Division of Public Health Services' electronic health record (EHR) was developed by Patagonia Health to allow for electronic reporting of all laboratory tests performed at the Division of Public Health. In the event a reporting error is made, steps must be taken to properly correct, document, and notify appropriate personnel of changes.

II. GUIDELINES:

A. Unsigned by Provider

- Results which have not been signed by the provider may be corrected on the preprinted electronic health record (EHR) order sheet.
- It is inappropriate to list only the last correction made as the clinician may have made a clinical decision based upon erroneous data rather than the "true" result.
- All corrections should be shown in the patient report.

1. Results Entered Incorrectly:

   a. Open the patient chart.
   b. Select Electronic Laboratory Results icon.
   c. Click on date to be corrected.
   d. Results entered for patient opens, scroll to the bottom.
   e. Select Edit.
   f. In-house Requisition opens in EHR.
   g. Correct the result.
   h. In the Date/Time/Read by box, ensure correct date, time and tech are entered.
   i. Scroll down to the Comments box.
   j. Document in Comments box. Include error, date, time, and tech.
   k. Click Save Lab Results.
   l. Result changes to Unsigned and will be sent back to the provider for review.

2. Result Entered on Wrong Patient

    a. Open the patient chart of the incorrect patient.
    b. Select Electronic Laboratory Results icon.
    c. Click on date to be corrected.
    d. Results entered for patient opens, scroll to the bottom.
    e. Select Edit.
    f. In-house Requisition opens in EHR.
    g. Scroll down to the Comments box.
    h. Document in Comments box. Include error, date, time, and tech.
    i. Click Save Lab Results.
    j. Result changes to Unsigned and will be sent back to the provider for review.

B. Signed by Provider

Test results have been signed by the provider are locked from editing; therefore, any changes must be made in a New In-house Lab Result.

1. Result Entered Incorrectly:

    a. Open the patient chart.
    b. Select Electronic Laboratory Results icon.
    c. Select New In-house Result Adult.
    d. Enter correct result.
    e. Scroll down to the Comments box.
    f. Document in Comments box. Include error, date, time, and tech.
    g. Click Save Lab Results.
    h. Result changes to Unsigned and will be sent back to the provider for review.

2. Result Entered on Wrong Patient

    a. Open the chart of the incorrect patient.
    b. Select the Electronic Laboratory Results icon.
    c. In the Laboratory widget click on desired Order Date.
    d. The entered results will appear. Scroll down until Assign To box appears.
    e. In the Comments box document incorrect patient information. Include error, date, time and tech.
    f. Click on Save.
    g. The result changes to Unsigned and will be sent back to the provider for review.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ELECTRONIC HEALTH RECORD – REFERENCE LABORATORY TESTS

DATE DEVELOPED: 4/15
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 2/16; 6/17; 6/18

I. POLICY:

The Rockingham County Division of Public Health Services' electronic health record (EHR) was developed by Patagonia Health to allow for electronic reporting of all laboratory tests performed at the Division of Public Health. This system also allows for the direct interface of tests performed at reference laboratories

II. GUIDELINES:

Interfaced Reference Laboratories

1. Currently, Quest Diagnostics is the only reference laboratory that is directly interfaced with the EHR.

2. The lab technician will come in at 8:00 a.m. and click on the *Dashboard*, click on *Patient's Name*, scroll down to bottom and put initials in the *Comment* box. Then click *Save* and *Close*. The provider can see report.

3. Abnormal results are indicated in red. The printed results of any abnormal labs are immediately relayed to the provider for review.

4. Click on the Electronic Lab Results icon to view available reference laboratory results.

Non-Interfaced Reference Laboratories

1. All other reference laboratory results are manually ordered on paper requisitions.

2. When results have returned, the paper copy is scanned without revision or further interpretation into the EHR.

3. Any scanned reference laboratory results for a patient will be located in the Lab/Radiology widget.

4. Click on the desired date to view and/or print results.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ELECTRONIC HEALTH RECORD – DOCUMENTATION OF CRITICAL VALUES

DATE DEVELOPED: 4/15
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

The Rockingham County Division of Public Health Services' electronic health record (EHR) was developed by Patagonia Health to allow for electronic reporting of all laboratory tests performed at the Division of Public Health. This system also allows for the direct interface of tests performed at reference laboratories. In the event a critical value is obtained, steps must be taken to properly document notification of appropriate personnel.

II. GUIDELINES:

The Patagonia EHR does not currently possess the capability of recognizing or flagging test values that are out of range or panic. Therefore, it is the responsibility of the personnel performing the test to properly recognize and document any value the agency deems critical or panic. (Refer to Panic Values.)

1. In the In-house Preprinted Lab Results scroll down to the Comments box.
2. Document the critical result, name of person result was reported to, the date, time and testing personnel's initials.
3. Click Save Lab Results.
4. Document results and contact information on the patient requisition and retain for two (2) years.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

MOBILE DENTAL UNIT
INDEX

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MOBILE DENTAL UNIT GUIDELINES AND EVALUATION CRITERIA

DATE DEVELOPED: 06/23
REVIEWED: 6/24
REVISED: 6/24

I. POLICY:

Dentist(s) directly employed, or who contract care for the Division of Public Health Services Dental Unit, are to provide care in accordance with the following guidelines.

II. PURPOSE:

These standards have been written to allow the dentist(s) a maximum amount of flexibility with which to provide care, and to do so in a manner, which has been determined to be appropriate, and of high quality. Dentists providing care for the Agency Mobile Dental Unit do so recognizing that their performance may be judged by any of the following evaluation criteria, which are directly related to the Guidelines. These standards are an integral part of the Quality Improvement Program.

III. GUIDELINES:

A. The mobile dental unit staff will provide dental services to eligible clients.

B. Eligibility/Recruitment: The community is informed of the mobile dental unit services through community outreach and school programs.

1. Clients will not be coerced to receive dental services. Services are provided solely on a voluntary basis.
2. Acceptance of a particular service is not a pre-requisite to eligibility for receipt of any other program/service involvement or benefits.
3. No person, on the grounds of race, color, age, religion, gender, marital status, national origin, sexual orientation, or handicapped status will be denied services or benefits. Handicapped clients requiring special equipment or expertise may be referred to specialist as warranted.
4. **Financial eligibility is based upon children that have active Medicaid. MDU coordinator will check eligibility to confirm if the child is eligible to be seen on the MDU on a school-to-school basis.**

C. Mobile Dental Unit Schedule:

1. Assessments, treatment, and services are offered by appointment. Appointments are made by the mobile dental unit coordinator.

2. Appointments are scheduled Monday – Thursday dependent on dentist and/or hygienist scheduling and availability.

D. Oral Diagnosis: Client Records

1. The dental record is complete and permits prompt retrieval. All entries are made within the Dentrix Electronic Health Record (EHR) System.

   Method of Assessment: Record review.

2. The dental record clearly documents the client's identification and biographical data (name, **Medicaid ID**, address, phone number, gender, date of birth, name and contact information of any legally authorized representative or individual to be contacted in the event of an emergency).

   Method of Assessment: Record review.

3. The client's positive history of allergic or adverse drug, food or substance reactions noted in the record.

   Method of Assessment: Record review.

4. Pertinent past medical history and current medications (updated annually of start of recorded dental treatment) are documented and easily identified. A new Medical History should be updated annually and reviewed every appointment.

   Method of Assessment: Record review

5. Dental progress notes are sufficient in detail to clearly indicate:

   a. date of service;
   b. procedure;
   c. tooth number;
   d. materials used;
   e. type and dose of anesthesia used;
   f. name and dosage of drugs prescribed;
   g. any additional pertinent information concerning the client or procedure;
   h. signature of treatment provider; and
   i. auxiliary staff signature if they make any entries.

Progress notes should be written out in plain language with minimal use of agency approved abbreviations or symbols. The universal tooth numbering system is recognized as the method of choice for tooth identification.

Method of Assessment: Record review

6. In case of emergency visits the SOAP format will be used.

Method of Assessment: Record review

E. Examination and Diagnosis:

1. Existing hard and soft tissue findings obtained by clinical and radiographic examination are recorded on the client's dental record.

Method of Assessment: Record review

2. Diagnosis is consistent with findings.

Method of Assessment: Record review

3. A plan of treatment is available in the client dental record and should be appropriate for the client's age, sex, and general health. The plan should be sufficiently flexible that it may be altered to accommodate unanticipated changes in the client's status or availability. All changes to the treatment plan should be documented as they are made. The documentations should describe rationales for the change and any further anticipated changes.

Method of Assessment: Record review

F. Prevention

1. All clients other than those seen only for emergency services have an individualized disease prevention plan based on the client's status and risk factors. The plan may include any of the following:

a. systemic fluoride;
b. professionally applied topical fluoride;
c. self-applied topical fluoride;
d. fluoride toothpaste;
e. pit and fissure sealants;
f. preventive periodontal treatment;
g. tobacco counseling;
h. oral health instructions and other health education; and
i. recall examination and prophylaxis.

Method of Assessment: Record review

2. Each dental prophylaxis provided meets the following standards:

   a. all plaque and other soft debris are removed from tooth surfaces, and the use of disclosing tablets is encouraged;
   b. all coronal calculus is removed (includes all supragingival calculus and subgingival calculus up to 3mm below gingival crest).
   c. all teeth are polished with prophy paste/rubber cup to remove stain and plaque.

   Method of Assessment: Record review for documentation.

3. Children (ages 5-14) presenting with one new smooth surface caries will be treated with topical fluoride at their prophylaxis appointment unless it is determined that they have enamel fluorosis.

   Method of Assessment: Review chart for documentation of fluoride applications and the factors supporting or not supporting the decision.

4. Occlusal sealants are placed on susceptible unrestored or incipient carious pit and fissure occlusal surfaces of permanent first and second molars with two years of eruption.

   Method of Assessment: Review of client record. Review should reflect that sealants are indicated for deep narrow pits and fissures in a sound tooth.

G. Radiographs: (this section is based upon the American Dental Association 2012 recommendations for prescribing dental radiographs – ADA Council on Dental Materials, Instruments, and Equipment).

1. All radiographic exposures shall be ordered by the dentist according to:

   a. Initial Adult Examination: An initial radiographic examination consisting of posterior bitewings supplemented with anterior and/or posterior periapical films and/or panoramic radiographs as required by oral conditions is recommended for all individuals 15 years and older. Panoramic or full-mouth intraoral radiographic films are appropriate when the client presents with clinical evidence of generalized dental disease, has a history of extensive dental treatment or requires assessment of position of unerupted teeth (e.g.: 3rd molar evaluation).
   b. Initial Child Examination:
      i. Primary dentition (prior to eruption of first permanent tooth)

Bitewing films supplemented with anterior and posterior periapical films as required by oral conditions when interproximal surfaces cannot be visualized or probed.

ii. Transitional Dentition (following eruption of first permanent tooth) Individualized radiographic examinations consist of periapical/Occlusal views and posterior bitewings or panoramic examinations as indicated.

c. Recall Examination:

i. Bitewing and/or periapical radiographs should be taken at intervals as required by the client's general condition and dental health history.

ii. Factors which may require increasing the normal frequency of radiographs at recall examination:

- high level of caries experience
- history of recurrent caries
- existing restorations of poor quality
- poor oral hygiene
- inadequate fluoride exposure
- high sucrose diet
- poor family dental health
- developmentally disabled
- xerostomia
- many multi-surface restorations

iii. In the absence of specific indications for more frequent radiographs, panoramic radiographs or a full-mouth intraoral periapical series should not be taken more often than once every five years.

d. Emergency Examination: An appropriate diagnostic radiographic examination of the area in question when indicated by signs and symptoms.

Method of Assessment: Review of client dental record and radiographs in client record. Radiographs should be appropriate for the signs and symptoms reported by the client and for the examination provided.

2. Dental Radiographs are dated, identified with the client's name and record number, and securely fixed to the client's dental record or recorded on the computer.

Method of Assessment: Review of client's dental record.

3. Density and contrast of radiographs are such that anatomical hard and soft tissue landmarks can be differentiated and identified.

4. Radiographic image size is not distorted in the area of the mouth under study.

5. Radiographs disclose no overlapping of image in the area of the mouth under study, except where tooth alignment does not permit open contacts.

6. Radiographs disclose no cone-cutting.

7. Bitewing radiographs include the distal surface of the erupted cuspids and the mesial surface of the most posterior erupted teeth.

8. Radiographs adequately target the area requiring evaluation.

   Method of Assessment for #3 through #8: Assess the radiographs within the past year. Applicable criteria used to determine diagnostic acceptability. The anatomy in the area under study should be visible and of diagnostic quality.

Note: If a radiograph has a deficiency, which does not compromise the diagnostic value, the radiograph will be considered acceptable. The peer review process should not encourage unnecessary radiographic exposure. The deficiency should, however, be pointed out to the evaluatee.

H. Radiological Protection

1. All dental auxiliaries who expose radiographs will possess all necessary state certifications to do so.

   Method of Assessment: Observe posting of current staff certificates reviewing necessary documentation.

2. Lead protective devices are used on each client during radiographic exposure.

   Method of Assessment: Observe radiographic procedures directly to determine if protective devices are used in an appropriate manner.

3. The tube housing or Nomad shall be stationary and positioned in close proximity to the film positioning device or skin of the client when the exposure is made. Method of Assessment: Observe directly whether the tube housing or Nomad is stationery and within ¼" or less of the film positioning device or skin when the exposure is made.

4. During exposure, radiographic film is not held in position by attending staff.

Method of Assessment: Direct observation of radiographic procedure.

5. During exposure, tube housing or Nomad is to be used as instructed.

   Method of Assessment: Direct observation of radiographic procedure.

6. Operator stands behind protective barrier during exposure.

   Method of Assessment: Direct observation of radiographic procedure.

7. Only necessary persons allowed in radiographic area during exposure.

   Method of Assessment: Direct observation of radiographic procedure.

I. Restorative

1. **Treatment is approved by the client's parent/verified personal representative by the signed General Consent Form for treatment prior to being seen for services. "Report Cards" are sent home with every patient after treatment that same day.**

   Method of Assessment: Direct observation of clients at time of examination and at initiation of treatment.

2. Tooth preparation and restoration are designed to make the best use of current materials and operative techniques to minimize trauma to the tooth and client while providing best esthetics and longevity of the restoration.

   Method of Assessment: Direct observation of completed restorations.

3. Esthetics of anterior restoration satisfies the requirement for color and contour of the adjacent teeth.

   Method of Assessment: Direct observation of completed restorations should reveal that they are aesthetically acceptable, and not displeasing to the client. The client may be asked to comment on the appearance of the restorations.

4. Instructions concerning restorative care are given to the client (parent/verified personal representative) postoperatively, and services planned for the next appointment are explained.

Method of Assessment: Direct observation of completion of a restorative dental appointment and/or review of the record to reveal documentation that post-op instructions were provided.

J. Pediatric Dentistry: Treatment Planning in the Primary Dentition.

1. It is recommended that primary posterior teeth with three or more carious surfaces or teeth receiving pulp therapy be restored with bonded composition or stainless steel crowns.

   Method of Evaluation: Record review.

2. All carious teeth are addressed in the treatment plan. In some instances that may simply imply observation, it should, however, be documented as such.

   Method of Assessment: Record review.

K. Behavior Management of Pediatric Clients

1. Behavior management of children shall be limited to voice control. No physical restraints will be used. Children who are unable to be controlled by these criteria shall be referred to a pediatric dentist. **If the provider must stop mid-treatment due to cooperation issues, it may become necessary for the dental assistant to hold the child until treatment can be safely stopped.**

   Method of Assessment: Record review.

2. The response to behavior management techniques, if used for clients less than six years of age, is noted in the progress notes.

   Method of Assessment: Record review.

L. Periodontics

1. When applicable, the record contains a written diagnosis by ADA-Case Type (Gingivitis, Early Periodontitis, Moderate Periodontitis, and Advanced Periodontitis). Note: because our client population has very many primary dental needs, periodontal therapy is usually limited.

   Method of Assessment: Record review.

2. The record contains the radiographic survey and periodontal probing values recorded on the visit when the initial periodontal evaluation occurred.

   Method of Assessment: Record review.

3. Periodontal treatment is documented, and consistent with the need indicated by initial diagnosis.

   Method of Assessment: Record review.

M. Oral Surgery: Indirect evaluation of extractions/surgical procedures:

1. The diagnosis leading to extraction or other surgical procedure is written in the dental record and is consistent with clinical findings.

   Method of Assessment: Review of the client's dental record will determine whether documentation for the diagnosis is recorded, including the availability of a preoperative radiograph. History, clinical symptoms, problem assessment and diagnosis are noted in the client's dental record in a SOAP or similar format.

2. Appropriate diagnostic preoperative x-rays are available in the client's dental record.

   Method of Assessment: Review of radiograph to assess presence of the entire tooth including the apex of the tooth (teeth) and surrounding pertinent anatomy.

3. Appropriate preoperative systemic antibiotic therapy is provided to clients requiring such, as specified by the American Heart Association.

   Method of Assessment: Review of the client's medical history record. Observe that those clients having noted a history of health problems suggesting antibiotic coverage have been questioned and/or their physician has been consulted for direction on the need for antibiotic coverage for any and all invasive dental procedures. If a prescription is written, it is documented that the client has complied with the regimen prior to such procedures.

4. Oral and written instructions concerning postoperative care of surgical or extraction services are given to **client and/or guardian,** and documented in the record.

   Method of Assessment: Observe whether oral and written instructions concerning postoperative care of surgical and/or extraction sites are given to the client before dismissal.

5. Informed consent is obtained for extraction procedures. This should include a discussion of risks, benefits, and alternatives to treatment.

   Method of Assessment: Review the client's record and observe the dentist providing informed consent discussion to a surgery client and/or guardian prior to care. Discussion should include risks,

benefits, treatment alternatives, client's and/or guardian's signature, dentist's signature and date.

N. Drugs

1. Drugs prescribed for and/or administered to dental clients are recorded in the client's dental record.

   Method of Assessment: Review of dental record and appropriateness of prescribed drugs and dosage for the written diagnosis.

2. Drugs administered or prescribed are consistent with the written diagnosis.

   Method of Assessment: Review of dental record for appropriateness of prescribed drugs and dosage for the written diagnosis.

3. Appropriate preoperative, systemic antibiotic therapy is provided to clients requiring such, as specified by the American Heart Association. Method of Assessment: Review client's medical history. Clients indicating history of conditions, which place them at risk for Subacute Bacterial Endocarditis (SBE).

4. All suspected adverse drug reactions are recorded in the dental history and reported as outlined in the Adverse Drug Reaction section of the Procedures for Pharmacy Services. Any allergies to medication(s) are prominently recorded in the record. If no drug allergies exist, the acronym NKDA (no known drug allergies) shall be documented in the record.

   Method of Assessment: Review of client's dental history and progress notes in the record.

5. Prescriptions which are called into a pharmacy shall be entered into the client's dental record at the time of the call.

   Method of Assessment: Review of dental unit protocols with the dentist, hygienist and/or mobile unit coordinator.

6. All drug stocks must be checked for expiration. All expired medication must be disposed of in accordance with Agency policy.

   Method of Assessment: Review of mobile unit logs at peer review audits.

O. Emergency Care Basic emergency diagnostic and treatment equipment shall be available in case of life-threatening episodes. All equipment is maintained and ready to use at all times:

• O2 tank is full;
• AED monthly BIT is completed;
• Ventilation Mask is attached to AED for immediate use when needed.

Method of Assessment: All mobile dental unit staff has current certification in Healthcare Provider Basic Cardiac Life Support (BCLS), and have been trained to call a code, notify 911, know where the O2 and automated external defibrillator. (AED) are located, and are trained to competently use this equipment under the guidance of the Dental Director and Physician Extenders.

P. Environment

1. All housekeeping activities have been performed before clinical day begins.

Method of Assessment: Observe the cleanliness and neatness of all areas of the mobile dental unit. If observation in the morning is not possible, then question the dental staff in accordance with the acceptability of the housekeeping activities being provided. Suggested areas to be considered are cleanliness of floors, walls, furniture, cabinets, dental chairs, dental units, wastebaskets, reception room tables, etc.

Q. Infection Control Practices in the Dental Treatment Environment

1. An infection control policy for the mobile dental unit has been reviewed and approved by the mobile dental unit's infection control committee/officer.

Method of Assessment: The infection control policy for the mobile dental unit is accessible and available for review by the mobile dental unit staff.

2. The requirements of the OSHA Bloodborne Pathogen Standard are met by having documentation of an exposure control plan, training and immunization record.

Method of Assessment: Review of the mobile dental unit staff, personnel records, and direct observation. All dental staff have been given the opportunity to be immunized for Hepatitis B and other diseases. Personnel records should provide dates of Tuberculosis skin testing (PPD). Follow-up action is documented for employees with a positive finding or conversion, which requires attention.

3. Accepted infection control procedures are practiced prior to, during and after client care.

Method of Assessment: Direct observation.

R. Client Preparation:

1. Coordinator and/or hygienist shall perform the following tasks for every client visit upon their arrival to the mobile dental unit:

   a. Retrieve client from classroom;
   b. Retrieves client's record in Dentrix EHR and confirms that client's birth date matches that of client being seen;
   c. Confirms that needed pre-medications, as indicated on dental record, have been taken the prescribed period of time before being seated in the treatment room; and

   Method of Assessment: Observe client preparation procedures accomplished by mobile dental coordinator and/or hygienist.

2. Mobile dental coordinator and/or hygienist shall perform the following tasks at each dental client visit:

   a. Escorts client to a prepared mobile dental unit chair;
   b. Confirms client's identity by matching birth date of client with that on the client's dental record;
   c. Verifies that treatment plan for this appointment is the same as that anticipated by the client, and that it addresses the client's immediate needs;
   d. Have client parent/guardian sign consent form, review medical history and sign/update forms annually. If medical history is older than 3 years, client parent/guardian is to complete a new Medical History form.
   e. Reviews medical alerts on examination page, confirming that necessary pre-medications have been taken the prescribed period of time prior to the appointment; and
   f. Introduces the client to the dentist as he/she enters treatment area, reviewing treatment planned, pre-medication taken (if required), and other medical conditions known to the mobile dental coordinator and/or hygienist which should be brought to the attention of the dentist.

   Method of Assessment: Observe client preparation procedures accomplished by mobile dental coordinator and/or hygienist.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MOBILE DENTAL UNIT SCHEDULE OF ORAL HEALTH SERVICES

DATE DEVELOPED: 06/23
REVIEWED: 6/24
REVISED: 6/24

I. POLICY:

The Division of Public Health Services Mobile Dental Unit provides oral health services to clients. The Agency Mobile Dental Unit utilizes established dental procedures, dental clinical guidelines and clinical evaluation criteria recommended by the American Dental Association. These services have been defined using CDT Codes, when available, to meet federal and state reporting requirements for reimbursement.

II. PURPOSE:

The schedule of services was developed to comply with an administrative interpretation of requirements of law and regulations described in the Health Centers Consolidation Act of 1996 and the Code of Federal Regulations, 51c Grants for Community Health Services, revised 1996 as well as the Human Services (DHHS) priorities as described in the draft publication entitled Bureau of Primary Health Care Oral Health Policy and Program Expectations for Community and Migrant Health Centers (1997).

III. GUIDELINES:

A. The **acting dentist on the MDU** is responsible for developing a primary oral health care plan, which addresses the needs of the community based upon financial feasibility.

B. The quality of dental care provided by the Agency Mobile Dental Unit shall be subject to continual monitoring and review. The Improving Organizational Performance Program shall include the following:

1. A quality workforce – will ensure that a high quality of dental personnel provide dental services through recruitment and selection efforts and the credentialing process.

2. A high standard of professional care – will ensure that a high quality of professional care is provided through a carefully structured, active review of dental services through regularly scheduled chart audits. The audits will focus upon appropriateness of care, comprehensiveness of care, and continuity of care.

3. A continuing performance improvement of health status outcomes – will ensure that the mobile dental unit is provided with a mechanism to record, review and improve certain quantifiable health outcomes consistent with the Health care plan adopted by this organization.

C. The scope of services for a Primary Oral Health Care Program are comprised of the following services and activities:

1. LEVEL I SERVICES – Acute Emergency Dental Services:

Emergency dental services are those necessary for the relief of acute problems involving the face, jaw, and teeth requiring immediate or urgent care. Emergency dental care services include all necessary procedures to manage the emergency, and stabilize the client. Services that eliminate acute infection, control bleeding, relieve pain, and treat injuries to the maxillofacial and intraoral regions - Activities – diagnosis, pulp therapy, tooth extraction, palliative or temporary restorations and fillings, periodontal therapy, and prescription of medications.

2. LEVEL II SERVICES – Prevention and Diagnosis:

Prevention and diagnostic services include those services intended to prevent the onset of the dental disease process. Prevention and diagnostic care may be directed at an individual or a community. Services that protect individuals and communities against disease agents by placing barriers between an agent and host and/or limiting the impact of a disease once an agent and host have interacted so that a client/community can be restored to health. - Activities – professional oral health assessment, dental sealants, professional applied topical fluorides and supplement prescriptions where necessary, oral prophylaxis and client education on self-maintenance and disease prevention.

3. LEVEL III SERVICES – Treatment of Dental Disease/Early Intervention Services:

Treatment of dental disease through early intervention includes those services deemed necessary to control the early stages of disease. These services are not complicated in nature and usually more than one procedure can be accomplished in an appointment. These services constitute the majority of mobile dental unit activities and include diagnosis and treatment on common oral diseases such as caries and periodontal diseases as well as less common oral conditions such as developmental abnormalities or abnormal growths, oral, nasal and pharyngeal infection. These functions include basic dental services that maintain and restore oral health

function. - Activities – restorative services which include dental fillings and periodontal services.

D. The mobile dental unit guidelines and evaluation criteria have been designed to allow the **acting dentist on the MDU** adequate latitude to develop a dental plan that is effective based upon the needs of the community and resources available to the Agency Mobile Dental Unit.

E. These protocols do require that all dental treatment meets or exceeds the accepted therapeutic guidelines of the American Dental Association as well as other relevant program regulations.

F. The aforementioned levels of care are prioritized. The lower levels of care include services, which are:

1. The most frequently needed;
2. The least costly to provide in terms of manpower or dollars, and;
3. Those which produce the greatest long-term benefits to oral health in the community.

The provision of emergency care has been considered mandatory and thus, it forms the first level of services. After Level I, those services which prevent oral disease, have been given greater priority than those intended to contain a disease process or to correct the damage caused by the consequences of disease.

G. The schedule of services and clinical guidelines are intended to provide direction for the staff of the Agency Mobile Dental Unit. The **acting dentist on the MDU** may use the schedule of services as a guide to develop a dental care delivery system sensitive to the needs and desires of the community while maintaining assurances that the cost-effective services are provided.

H. It should be noted that while the prioritized levels of care identify those services which will provide the greatest good to the greatest number in a community, administrators and the dental director must consider the benefit to the financial viability of their program according to the financial resources available to the Agency Mobile Dental Unit.

I. The Division of Public Health Services Mobile Dental Unit shall endeavor to maintain regular mobile unit hours of operation, which shall best meet the needs of the community being served.

J. It shall be the intent of the Agency Mobile Dental Unit to provide dental services to the target population.

K. The Agency Mobile Dental Unit shall maintain adequate flexibility in their appointment scheduling system to allow for evaluation of emergency problems, clients with special problems and new clients. It is understood that should the demand for care exceed the Agency Mobile Dental Unit's capability to provide such care, it may be necessary and appropriate to take measures to place limitations on the availability and nature of that care. Limitations or exclusions of care must take into consideration the mobile dental unit's various contractual commitments, the mobile unit size, staffing, and financial resources.

L. The Agency's Mobile Dental Unit shall endeavor to facilitate client flow by employing such measures as:

1. Closely following the schedule within the Dentrix system which is easily accessible by all dental staff;

2. Allowing mobile dental unit staff complete appointment book control;

3. Maintaining a well-trained chairside assisting staff, preferably certified to provide all expanded functions allowed by the NC's Dental Practice Act;

4. Maintaining dental equipment to prevent down time of a portion of the mobile unit;

5. Maintaining an adequate supply of sterile instruments and supplies;

6. Adequate cross-training of staff to allow for unexpected absences of critical staff;

7. Ensuring that auxiliary staff are trained to minimize the efforts of the dentist by adequately preparing client and treatment rooms, i.e. all instruments required for initiating care are at hand, lipstick removed, napkin placed, operatory fully equipped with sterile handpiece, etc.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MOBILE DENTAL UNIT RECORD POLICY

DATE DEVELOPED: 06/23
REVIEWED: 6/24
REVISED: 6/24

I. POLICY:

The Division of Public Health Services Mobile Dental Unit shall maintain a clinical record on each client receiving services through the dental program. The clinical record contains pertinent past and current dental, medical, social, and therapeutic information. All dental services, whether through direct client care or phone interviews are documented in the clinical record. Each mobile dental unit employee is responsible for their own documentation. Also, any interaction with the client's primary care provider should be documented in the clinical record. A note must be written for each encounter made.

II. PURPOSE:

To maintain the required information for each client seen through the Agency Mobile Dental Unit in order to collaborate services and provide a more holistic approach to their dental care.

III. GUIDELINES:

A. The Agency Mobile Dental Unit client record shall contain the following:

1. Radiographs
2. Copy of client's insurance/Medicaid card or household income documentation for grant money guidelines
3. **General Consent Form, signed by the parent/legal guardian**
4. Medical History; updated annually
5. Dental Examination
6. Progress Notes
7. Correspondence

B. All client registration data is entered into the Dentrix EHR computer database of the agency. The registration form is scanned in the client's record.

C. Client dental records are maintained in the Agency Mobile Dental Unit and are considered Protected Health Information (PHI) as required by HIPAA Privacy Regulations.

D. The Agency Mobile Dental Unit employees are required to attend orientation and annual HIPAA Privacy Training. Under no circumstances is PHI to be shared with any person other than staff who have a need to know related to treatment, payment or healthcare operations related to the provision of dental health care.

E. A separate data grouping may be kept for client recall information. This data may be kept apart from the dental clinic record and may include information only pertaining to client record number, client name, address, telephone number, names of parents or verified legal representative and dates of anticipated recall appointments. This data should not contain health care information.

F. Clients who desire a copy of their mobile dental unit record set shall be granted access upon meeting guidelines outlined in the Agency HIPAA Policy, Accommodation of Client Right to Access Protected Health Information. Under no circumstances may any staff member turn over or lend the original copies of client dental records or x-rays to clients, or their verified personal representative.

G. Quarterly Dental Program Audits will be performed to monitor the provision of care, documentation, and billing as part of the Improving Organizational Performance (IOP) Quality Assurance Program.

H. Interpreter services are utilized for the limited English proficient clients. The clinical professional will document care provided. The name of the interpreter will appear on the chart. Under no circumstances is the interpreter permitted to document findings on the client's clinical record.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMERGENCY DENTAL CARE ON THE MOBILE DENTAL UNIT

DATE DEVELOPED: 06/23
REVIEWED: 6/24
REVISED: 6/24

I. POLICY:

The Division of Public Health Services Mobile Dental Unit shall make every effort to assist clients requiring emergency care.

II. PURPOSE:

From time to time, clients will present with serious dental emergencies on the mobile dental unit. This policy outlines measures that may be taken in response to clients in need of emergency dental care.

III. GUIDELINES:

A. Clients may only been seen on the mobile dental unit in cases of severe dental emergencies in the following manner:

1. The mobile dental unit shall see a client for immediate treatment, or
2. After an examination, the client will be prescribed appropriate medications to relieve pain and/or infection until an appointment can be scheduled, or
3. A client may be referred to an appropriate primary care clinic for medical evaluation and needed prescriptions until the client can schedule an appointment outside of the mobile dental unit for required care, or
4 The client may be referred to another dental office, or
5. The client may be referred to the nearest hospital emergency room.

B. The mobile dental unit shall block appropriate units of time to accommodate clients needing emergency care.

C. The dentist/hygienist may deem it necessary to refer a client to another office if:

1. The mobile dental unit is unable to provide the necessary care required.
2. The mobile dental unit determines that the client would be better served in a different setting or requires services that the mobile dental unit cannot provide.

D. When a client is referred to an outside provider for required services, the following procedure must be followed:

1. The dentist or a member of the dental staff shall contact the dentist, physician, or physician extender concerning the nature of the referral or a written referral form will be given to the client.

2. The dentist or the mobile dental unit staff shall document the referral in client's dental record and include the following information:

   a. the date the referral was made;
   b. referral source name and telephone number; and
   c. the date and time of the client's appointment with the referral source, if the dental clinic staff scheduled the appointment.

3. All correspondence with the referral source will be documented in the client's dental record including follow-up letters, reports and/or radiographs.

4. If a referral form is completed, it is to be placed in the client's clinical record, and a copy will be sent with the client with the appropriate referring information listed.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MOBILE DENTAL UNIT QUALITY IMPROVEMENT PROGRAM

DATE DEVELOPED: 06/23
REVIEWED: 6/24
REVISED: 6/24

I. POLICY:

The Division of Public Health Services Mobile Dental Unit will strive to maintain the highest quality of dental care possible by ensuring a high quality workforce through a careful recruitment and selection effort. The Agency participates in a Quality Improvement Program to assure compliance with all federal, state, local and Agency guidelines and regulations.

II. PURPOSE:

The Quality Improvement Program is an ongoing program that continually assesses quality of services provided to clients of the Agency.

III. GUIDELINES:

A. Clinical productivity and mobile dental unit staff productivity shall be evaluated by any number of methods, including but not limited to:

1. Measures including those associated with Relative Value Units will be utilized. These values evaluate the efficient use of a provider's time and determine the number of fifteen minute measures of time that a provider expends providing client care for a specific procedure.

2. Financial activity reports also evaluate mobile dental unit staff productivity. It is crucial that the mobile dental unit generates adequate income to maintain its financial viability. The Dental Director shall recognize and accept the administrative responsibility for the program.

B. Client encounters, which have historically been the basic productivity measure, will continue to be monitored. It is recognized that the amount of time required for various procedures can vary from a few minutes to a few hours. Thus, the number of client encounters in the mobile dental unit can be highly variable from day to day.

C. Quality clinical care shall be assured through an active carefully structured dental record. Documentation of care within the record shall focus upon appropriateness, comprehensiveness, and continuity based on regularly

scheduled quarterly record audits. The information generated by the dental program audits shall be used by the dental director and dental staff to formulate methods of improving the care provided to the dental clinic clients.

1. A minimum of 10 clients served during these quarters will be reviewed. All disciplines will be included in the record audit.

2. The purpose of the record audit will be to: - Ensure that the level of dental care specified by the policies and dental codes, procedures and protocols of the dental program are being met. - Discuss problems in the mobile dental unit and make recommendations to correct deficiencies found.

3. Chart selection will be based on randomly selected records from the quarter in review.

4. The results of the audit will be tabulated and recorded in minutes and filed within the mobile dental unit. Information discussed within the report will have the client MR number, rather than any other identifying data.

5. The strengths and weaknesses will be identified and summarized along with a corrective plan of action.

6. A program annual evaluation will be completed with the mobile dental unit director/dentist and the staff development coordinator. This annual summary will include the results of the fiscal year quarterly audits, the program strengths and weaknesses, changes that occurred within the program and any areas of improvement as addressed for the upcoming year.

7. At the end of the fiscal year, we will review programs to identify any unmet needs and establish guidelines for the upcoming fiscal year.

D. Other measures of assuring quality service will be the investigation of client complaints, which relate to the quality of care provided in the mobile dental unit. All complaints shall be documented and reviewed with the Agency staff involved and measures will be identified to prevent future occurrences.

- Staff will be notified of comments and results. Areas for improvement will be addressed.

E. The mobile dental unit shall endeavor to create measures that help improve services delivered to our clients. Quality shall always be an issue of key consideration with the Agency Mobile Dental Unit. As such, our efforts to track quality will continually be evolving. The measures utilized currently will be revised as our program develops improved methods of

documentation, newer treatment modalities and clinical techniques, and enhanced care delivery procedures.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MOBILE DENTAL UNIT RISK MANAGEMENT

DATE DEVELOPED: 06/23
REVIEWED: 6/24
REVISED: 6/24

I. POLICY:

The Division of Public Health Services Mobile Dental Unit shall provide dental care utilizing current recommended modalities to prevent litigation related to issues of care provided by the mobile dental unit staff.

II. PROCEDURE:

A. The increasing influence of litigation on dentistry has resulted in an effort by the profession to reduce the risk of legal liability by closely examining all aspects of client care. The purpose of this review process is to provide the best possible client care and to reduce risk factors.

B. In most situations, miscommunication and misunderstanding between the dentist and client is an important contributing factor. This policy reviews concepts of liability and risk management and discusses methods of risk reduction.

C. The most important factors in risk reduction are good documentation and good communication.

III. GUIDELINES:

A. The foundation of dental practice is based on evidence-based medicine. In addition to excellence in clinical practice, other aspects of client care may significantly affect liability. These include:

1. Dentist, client, **parent/guardian** communication;
2. Client information;
3. Informed consent;
4. Proper documentation, and;
5. Appropriate management of complications.

B. One method of improving the dentist-client relationship is to provide clients/**parent(s)/legal guardian(s)** with as much information as possible on any specific problems that the client may have, their relationship to overall health, and methods of managing them. Well-informed clients

generally have a much better understanding of specific problems and more realistic expectations about treatment outcomes. Efforts by dental practitioners to provide information to clients generally improve client rapport.

C. The current concepts of informed consent are based on providing the client the necessary information and obtaining a consent signature for a procedure. In addition to fulfilling the legal obligations, there are several benefits of obtaining the proper informed consent from clients. First, well-informed clients who understand the nature of the problem and have realistic expectations are less likely to be unhappy or behave litigiously. Second, a properly presented and documented informed consent can prevent unmeritorious claims based on misunderstanding or unrealistic expectations of the client. Finally, obtaining informed consent offers the dentist the opportunity to demonstrate greater personal interest in the client's health and welfare. Greater client acceptance and understanding of treatment pros and cons leads to greater rapport.

D. The dentist should discuss all aspects material to the **client/parent(s)/legal guardian(s)** decision to undergo treatment, even if it is not customary to provide such information. When a reasonable person is likely to attach significance to an adverse or unpleasant event during or after a procedure, it is considered a material note.

E. Informed consent consists of three phases:

1. Discussion,
2. Written consent – **in the General Consent Form**
3. Documentation in the client's record

F. A discussion of the appropriate issues should take place between the dentist and client**/parent(s)/legal guardian(s).**

G. The discussion should include information about:

1. The specific problem;
2. Proposed treatment;
3. Anticipated common side effects;
4. Possible complications and frequency of occurrence;
5. Anesthesia;
6. Treatment alternatives; and
7. Uncertainties about final outcome, including a statement that the treatment has no absolute guarantees or warranties.

H. The Agency Mobile Dental Unit has developed **a general consent form that contains** the informed consent in both English and Spanish. They are to be used prior to any dental treatment on the mobile dental unit. The

information must be presented so that the client/**parent(s)/legal guardian(s)** has no difficulty understanding it.

I. At the conclusion of the discussion the client/**parent(s)/legal guardian(s)** must be given an opportunity to ask any remaining questions.

J. Staff will inform the client that translator services are available **through the Rockingham County Department of Public Health by a phone call if the client has a general consent form given back in Spanish**. If the Division of Public Health Services staff translation services are utilized, the first and last name of the translator needs to be identified within the documentation on the client's record. Some clients/**parent(s)/legal guardian(s)** may choose the interpretive assistance from a family member or friend **over the phone**. If so, staff should inform the client that confidential information may be revealed. Then allow the client to choose their translator source. Minor children (under 18 years of age) should not be used as the interpreter unless it is an emergency service or extenuating circumstances where the client's services are needed right away and no one else is available. If the client chooses to continue with the family member as the interpreter, this should be documented within the client's clinical record and documented that the Division of Public Health Services' Interpreter services were available and offered.

K. An individual who speaks but does not read a language provided on the consent form shall receive the discussion in their language by a member of the school staff. This situation being far from ideal must be extremely well documented. The **staff member** should sign the English document indicating that a foreign language translation was performed providing the name of the interpreter.

L. There are three special situations in which an informed consent may deviate from these guidelines:

- A complete informed consent may not be necessary in an emergency, when the need to proceed with treatment is so urgent that unnecessary delays to obtain an informed consent may result in further harm to the client. It should be noted that while many dental conditions may seem urgent in the eyes of the dentist, the reality is that most can be stabilized without invasive procedure, allowing the client time to confer with family members or even seek a second opinion.

M. In spite of the best efforts in diagnosis, treatment planning, and technique, the outcome of a procedure is sometimes less than optimal. A poor result does not necessarily suggest that a practitioner is guilty of negligence or other wrongdoing. If significant medical complications occur during a

procedure, the dentist shall immediately address the problem in the most appropriate manner.

N. The dentist should discuss the nature of the complication with the client/ parent/guardian or verified legal representative. Examples of such situations are loss or failure to recover root tip, perforation of the maxillary sinus, damage to adjacent teeth, inadvertent fracture of surrounding bone, separated endodontic file, etc. In these instances the dentist should clearly outline proposed management of the problem including specific instructions to the client**/parent(s)/legal guardian(s)**, further treatment that may be necessary, and referral to an oral surgeon, endodontist, periodontist, etc. when appropriate.

O. In some instances untoward events result from errors, for example extraction of the wrong tooth. As soon as the error is recognized, it should be honestly discussed with the client parent/guardian or verified legal representative. It is best to consider practical treatment options, which can produce a reasonable outcome and appropriate treatment. In many such instances a referral to a specialist should occur in order to help determine the most appropriate action. If a problem occurs with a child, the parents/guardian or verified legal representative should be notified immediately. The dentist must assume the responsibility of discussing the situation with the parent/guardian or verified legal representative and recommending solutions that may remedy the problem.

P. It is essential to notify the malpractice carrier of any situation, which might lead to litigation. Clearly if a client threatens to discuss the problem with an attorney the malpractice carrier must be notified. It is important to refrain from arguing with the client or the client's verified legal representative. Finally, it is imperative that the record accurately reflects the details of the occurrence. No additions, deletions, or changes of any sort should be made to the original documentation of the event. Records must not be misplaced or destroyed according to the Agency records retention policy.

Q. Avoiding Client Abandonment: Having accepted a client for care and initiated treatment, the dentist is obligated to provide care until the treatment is **complete or referral is given**. There is an obligation of the Division of Public Health Services to continue to treat clients. **In the case a client has changed schools, the parent(s)/legal guardian(s) are to be contacted via phone for a verbal referral of that client.**

V. Client Termination: If a situation should arise in which the dentist-client**/parent/legal guardian** relationship has been damaged to the degree that client care should be terminated, the **acting MDU dentist** must follow certain steps before discontinuing treatment to avoid being accused of client abandonment. They are:

1. Approval to terminate care must be obtained from:

    a. The Rockingham County attorney
    b. The Division of Public Health Services Director

2. A letter must be sent to the client, parent/guardian or verified legal representative, indicating the intent to withdraw from the case and terminate care at the Agency mobile dental unit.

    a. The letter must explicitly include the reasons for the decision to discontinue treatment, and
    b. The letter should be sent by certified mail to ensure that the client does in fact receive it.

3. The dentist must continue to remain available for treatment of emergency problems for 30 days.

4. The dentist must offer to forward copies of all pertinent records that affect client care.

W. In addition to providing the best technical care, the dentist must address several other aspects of client care to minimize unnecessary legal liability. The dentist should develop the best possible rapport with clients through improved communication, providing any information that may improve their understanding of treatment. Adequate documentation of all aspects of client care is also necessary

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: MOBILE DENTAL UNIT ACTIVE SHOOTER GUIDELINES

DATE DEVELOPED: 06/23
REVIEWED: 6/24
REVISED:

I. PURPOSE:

The Division of Public Health Services will establish a plan to ensure work site safety for its employees and clients. The county's Active Shooter Response Guideline will be followed. An Active Shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area; in most cases, active shooters use firearms(s) and there is no pattern or method to their selection of victims. Active shooter situations are unpredictable and evolve quickly. Typically, the immediate deployment of law enforcement is required to stop the shooting and mitigate harm to victims. Because active shooter situations are often over within 10 to 15 minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active shooter situation.

II. SCOPE:

To identify a means of evacuation from the mobile dental unit or taking cover in the event of an unsafe surrounding which may be due to an active shooter on school grounds or some type of physical threat to the school.

III. GUIDELINES:

A. If you hear shots fired on campus or if you witness an armed person shooting or threatening people (active shooter): Immediately choose the best way to protect your life. Very quickly, make your best determination of what is occurring and which of the options below will provide the greatest degree of security for you employing the "RUN, HIDE, or FIGHT" protocol.

1. RUN: Evacuate If Possible

   a. If there is considerable distance between you and the gunfire/armed person, quickly move away from the sound of the gunfire/armed person. If the gunfire/armed person is in your building and it is safe to do so, run out of the building and move far away until you are in a secure place to hide.
   b. Leave your belongings behind.
   c. Keep your hands visible to law enforcement.
   d. Take others with you, but do not stay behind because others will not go.

e. Call 911 when it is safe to do so. Do not assume that someone else has reported the incident. The information that you are able to provide law enforcement may be critical, e.g. number of shooters, physical description and identification, number and type(s) of weapons, and location of the shooter.

2. HIDE: Hide silently in as safe a place as possible

a. If the shooter is in close proximity and you cannot evacuate safely, hide in an area out of the armed person's view.
b. Choose a hiding place with thicker walls and fewer windows, if possible.
c. Lock doors and barricade with furniture, if possible.
d. Turn off lights.
e. Silence phones and turn off other electronics.
f. Close windows, shades and blinds, and avoid being seen from outside the room, if possible.
g. If you are outdoors and cannot RUN safely, find a place to hide that will provide protection from gunfire such as a brick wall, large trees or buildings.
h. Remain in place until you receive an "all clear" signal.

3. FIGHT: Take action to disrupt or incapacitate the shooter

a. As a last resort, fight. If you cannot evacuate or hide safely and only when your life is in imminent danger, take action.
b. Attempt to incapacitate or disrupt the actions of the shooter.
c. Act with physical aggression toward the shooter.
d. Use items in your area such as fire extinguishers or chairs.
e. Throw items at the shooter if possible.
f. Call 911 when it is safe to do so.

B. Immediately after an incident:

1. Wait for Local Law Enforcement officers to assist you out of the building, if inside.

2. When law enforcement arrives, students and employees must display empty hands with open palms.

GUIDELINES:

- Understand that gunfire may sound artificial. Assume that any popping sound is gunfire.

- If there are two or more persons in the same place when a violent incident begins, you should spread out in the room to avoid offering the aggressor an easy target.

- Be mindful that violent attacks can involve any type of weapon, not just a gun. Knives, blunt objects, physical force or explosives can be just as deadly as a gun. The suggested actions provided here are applicable in any violent encounter.

- Plan ahead: Visualize possible escape routes, including physically accessible routes for students and staff with disabilities and others with limited mobility.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MOBILE DENTAL UNIT CONSENT PACKET PROCEDURE

DATE DEVELOPED: 06/23
REVIEWED: 6/24
REVISED:

I. POLICY:

The mobile dental unit coordinator is responsible for distributing health history and consent packets to each school prior to arrival (30-60 days prior if possible). The school staff disburses these packets to each class and collects them as they are returned to school. The mobile dental unit coordinator periodically makes contact with the school staff to coordinate pick-up of these packets for processing. No forms will be accepted for that school visit once deadline has passed. Only students with completed forms will be seen during that visit to the school once deadline for forms to be in has passed. Deadline will be set by the mobile unit coordinator when forms are dropped off at the school.

II. PURPOSE:

Outline the appropriate steps for processing packets from a school prior to Mobile Dental Unit arrival on site. The scope of the procedure applies to all Mobile Dental Unit staff.

III. GUIDELINES:

1. Upon receipt of the consent forms, the Mobile Dental Unit Coordinator will review all consents to be sure they are all completed. Incomplete forms are to be returned to the school to be redisbursed to those students once more to be completed. Any incomplete forms will not be accepted.

2. Upon receipt of complete packets from the schools, the packets will be given to the Mobile Dental Unit Coordinator to sort into categories. These categories are new patients and returning patients. Charts will be compiled as Comprehensive or Periodic.

3. Each team member will then have the shared responsibility of updating information, pulling existing charts, creating new charts, gathering NC Tracks information to verify Medicaid and any other tasks for getting the prospective school ready for mobile dental unit arrival.

4. Each team member is responsible for the administrative duties surrounding new packets and health history updates that come in each day from the School Health Nurse.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: MOBILE DENTAL UNIT EMERGENCY EVACUATION GUIDELINES

DATE DEVELOPED: 06/23
REVIEWED: 6/24
REVISED: 6/24

I. PURPOSE:

The Division of Public Health Services will establish an evacuation plan to ensure work site safety for its employees and clients. The county's Emergency Response Plan Guide will be followed.

II. SCOPE:

To identify a means of evacuation from the mobile dental unit in the event of an unsafe surrounding which may be due to fire or some type of manmade or natural disaster.

III. AUTHORITY AND REFERENCES:

Rockingham County Board of Commissioners has assigned the responsibility, authority and accountability for safety to all department heads, supervising personnel and employees.

References:

- Rockingham County Government Employee's Safety and Health Handbook
- Rockingham County Government Emergency Response Plan Guide
- Rockingham County Fire Marshal

IV. GUIDELINES:

A. The Division of Public Health Services will work in collaboration with the Fire Marshal to establish a safe evacuation route.

B. The agency will ensure that the following safety measures are in place:

1. Adequate number of building exits.
2. Exits cannot be blocked from the inside so as to prevent free escape at any time.
3. Exits must be clearly marked and visible with no obstructions.
4. Lighting must be adequate to see exits.
5. No structure under construction or remodeling can be occupied if exits are unavailable/blocked.

6. All devices designed to assist emergency evacuation (fire doors, alarm systems, fire extinguishers, etc.) should remain continuously in proper operating condition.

IV. EMERGENCY PLAN REQUIREMENTS:

A. Escape procedures are as follows:

1. Staff and clients should evacuate down the stairs closest to their location at the time of the alarm.

   There are 2 exits available:

   - The **side** of the mobile dental unit.
   - The back of the mobile dental unit.

   The staff and clients must exit **through the closest emergency exit. If exiting the back of the MDU, the exit door is at the back of the MDU and down the steps. If exiting through the staff entrance, the exit is on the side of the MDU and down the steps.**

2. Staff are instructed to assist clients out of the building during evacuation.

3. Staff are expected to exit the facility as quickly as possible and take their personal belongings before evacuating.

4. Currently there are no staff identified as a critical operator – which means no staff should stay in the facility.

5. All staff are expected to relocate in one general area to account for staff. All Mobile Dental Unit staff will relocate in the area determined by the school the mobile dental unit is located at. No matter which exit the employees and clients take, all are expected to gather at this location for a count.

6. Post evacuation will include the Mobile Dental Unit supervisor or department head at that time to account for their program staff. Supervisor or department head should do a head count on how many people are on the unit before exiting to ensure everyone is off of the unit.

   Once at the evacuation site – supervisors or department heads will recount staff and clients. Staff are expected to get clients to their current teacher once they are safely off the mobile dental unit.

7. Clinical staff should immediately congregate. Staff would assess the need for triage if injuries occur.

8. The clinical staff working will remove the oxygen tank and emergency materials if possible. This can be used to provide medical services if needed.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MOBILE DENTAL UNIT MEDIA RELEASE FORM PROCEDURE

DATE DEVELOPED: 09/23
REVIEWED: 6/24
REVISED: 6/24

I. POLICY:

The Rockingham County Department of Public Health Mobile Dental Unit the absolute right and permission to publish, copyright and use photography/statements of students and/or parent/guardian in which the child/dependent and/or parent/guardian may be included in whole or in part and/or composite or retouched in character or form without compromising the integrity of the photo. Any photograph/statement produced may be used for publication including but not limited to annual reports, mass paper publications, internet publications limited to Rockingham County Department of Public Health websites and its affiliates, etc. Any photograph/statement taken will be considered the property of The Rockingham County Department of Public Health without compensation to students and/or parent/guardians and may be used at the Department's discretion solely for the purpose of promoting the services of the Department. Duplicates may be made for and used by employees/independent contractors of the Rockingham County Department of Public Health and may be transmitted via email for an indefinite period of time. Photographic images and/or other materials of students and/or parent/guardians used by the Rockingham County Department of Public Health will be portrayed in a manner that will promote improving overall health in the Rockingham County community. In Regards to the Division of Public Health and in order to maintain the privacy and integrity of patients, exam room photographs will only be taken in posed situations and never during an actual exam. Under no circumstances will medically confidential information be disclosed for promotional use unless permission is granted by the participant.

If the person photographed is under 18, his or her parent or legal guardian must give consent on his or her behalf for the terms and conditions stated on the media release **which is located on the back of the MDU General Consent Form. A parent/legal guardian is to give consent for the media release by circling "Yes" on the front of the General Consent Form after it reads *"I have read and agree to the Media Release for the Mobile Dental Unit"* on the back page**. The Rockingham County MDU Staff is responsible for **checking the front of the General Consent Form for the "Yes" to be circled** any time a photograph or statement is being taken/received on/in regards to the MDU to each parent/guardian in an event that a photograph or statement is being taken/received.

II. PURPOSE:

Outline the appropriate steps for processing a media release form for the Mobile Dental Unit.

III. GUIDELINES:

1. In the event a photograph/statement is taken/received the MDU staff is to **check the front of the General Consent Form to ensure the parent/legal guardian of the child circled "Yes" where it states *"I have read and agree to the Media Release for the Mobile Dental Unit"* on the back page.**

2. Each team member will then have the shared responsibility of taking photographs/statements and ensuring **the parent/legal guardian has circled "Yes" on the General Consent Form. The team member sharing that photograph/statement is responsible for checking the General Consent Form before releasing any media.**

3. **Once the General Consent Form has been verified that the media release consent has been circled "Yes" and the General Consent Form is signed, it is to be scanned into the Dentrix Document center. The picture may then be published for promotional purposes of the Rockingham County Mobile Dental Unit.**

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: MOBILE DENTAL UNIT ARRIVAL AT SCHOOL GUIDELINES

DATE DEVELOPED: 09/23
REVIEWED: 6/24
REVISED:

I. POLICY:

The Division of Public Health Services will establish an arrival plan to ensure guidelines for its employees and clients. The county's arrival upon school location guidelines will be as follows.

II. PURPOSE:

To identify a means of guidelines for the mobile dental unit when arriving at a new school to begin seeing patients.

III. GUIDELINES:

1. Upon arrival to the school the mobile dental unit staff is to request a master schedule of the school which gives them the teachers' names and daily schedules.

2. Upon arrival to the school the mobile dental unit staff is to request a school radio, which ensures safety and communication between the school and mobile dental unit.

3. Upon arrival to the school the mobile dental unit staff is to request a school badge for entry into the school (when applicable).

4. Upon arrival to the school the mobile dental unit staff is to be provided the schools emergency protocol plan for severe weather, fire, and any other emergency that may occur.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: INFECTIOUS DISEASE OF A PATIENT STANDARD PRECAUTIONS

DATE DEVELOPED: 01/24
REVIEWED: 6/24
REVISED:

I. POLICY:

The Division of Public Health Services' staff will follow standard precautions at all times when providing direct care to patients. The Mobile Dental Unit Staff has established this policy to help prevent the spread of infectious disease to the Mobile Dental Unit Staff and the community. The Mobile Dental Unit has the right to turn down seeing a patient for that particular visit if the staff sees that patient is visibly ill.

II. PURPOSE:

To protect the Mobile Dental Unit Staff and the community from infectious diseases being spread on the Mobile Dental Unit.

III. GUIDELINES:

Infectious diseases are major health hazards in the health care industry. Precautions and personal protective equipment must be used to eliminate or minimize exposure to infectious diseases.

A. Evaluate every patient when you bring them out to the MDU by observing them.

B. Put on proper PPE (i.e., mask, glasses, gown/jacket, gloves, shoes).

C. If you think they may be contagious, before beginning any treatment, the following protocol must be followed:

1. Take the patients temperature. If the temperature is above 100°, the patient is to be immediately returned to the school.
2. If the patient has a hacking cough, the patient is to be immediately returned to the school.
3. If the patient is showing signs of fatigue, the patient is to be immediately returned to the school.
4. If the patient complains of a stomach ache, the patient is to be immediately returned to the school.
5. If the patient is having any flu-like symptoms, the patient is to be immediately returned to the school.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

MOBILE DENTAL UNIT ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A. Division of Public Health Services 1. Mission, vision, goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B. Review of Policies: 1. Agency Safety a. Fire Prevention and plan b. Smoke Sensors c. Fire Extinguishers d. Exit Signs e. Security f. Tornado Plan g. Emergency Preparedness - Automatic External Defibrillator - Dental Clinic Disaster Training - Dental Clinic Disaster Assistance - Emergency Shelters and Team Assigned		
2. Personal Safety a. Agency worksite b. Vehicle Safety c. Threatening behavior d. Medical emergencies - Clients - Employees - Staff training for: * CPR * Automatic External Defibrillator * Infection Control		

3. Infection Control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and Handling Supplies g. Standard Precautions h. Blood borne Pathogens i. Vaccinations * TB Skin Test * Hepatitis B or Waiver * Rubella * Tetanus * Influenza * Varicella j. Equipment Management * Vaccine transporting * Handling & Storage k. Identifying, Handling and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment * Gloves * Impermeable Gown * Antibacterial Hand Wash * Spill Kit * N-95-Respirator Mask * Goggles/Face Shield		
C. Preceptor Assigned		
D. Orientation Period		
E. Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable) 4. Scope of services and program policy review 5. Dental Clinic a. Charting System – * Health History – Updated every year * Patient Information with demographics * Treatment Plan * Progress notes * Copies of radiographs * Consents for treatment * Narratives are written with date and services rendered – including		

notations for follow-up * referrals are documented b. Dentrix charting system c. Documentation (if having to use paper charts) * How to correct entries * Writing neat and legible * Most recent note on top * Dental staff – hygienist have direct supervision * Consents Forms/Release of Information * Consent to photograph * Dental approved – standardized abbreviations * Client referral form * Follow-up of abnormal findings * Encounter Form		
6. Mobile Dental Unit Expectations of the Mobile Dental Unit Staff * Report to clinic as assigned in a timely manner * Review chart prior to client contact * Introduce self to client & state purpose * Use appropriate communication skills * Assess needs, health history, and current status/document appropriately * Implement and document problems based on assessment * Implements, carries out and document appropriate care * Reviews and updates job description annually * Adheres to dress code displaying a professional appearance * Establishes an effective working relationship with others * Reliable in following procedures/policies * Provides dental services to clients according to standards, program guidelines and collaborates with other health care disciplines. * Treats public with courtesy & respect * Maintains complete confidentiality of client information		
7. Accreditation process-development, implementation and maintenance.		

Employee's Signature: _____ Date_____

Supervisor's Signature:_____ Date_____

Employee's Signature: _____ Date_____

Supervisor's Signature:_____ Date_____

Employee's Signature: _____ Date_____

Supervisor's Signature:_____ Date_____

* When completed the employee needs to submit to dental office management support for filing.

* The Orientation Checklist should be completed at the end of the employee's probationary status.

Date Developed: 06/23
Reviewed: 6/24
Revised:

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

MOBILE DENTAL UNIT MANAGEMENT SUPPORT ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A. Division of Public Health Services- 1. Mission, Vision, and Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B. Review of Policies: Agency – HIPAA-Policies & Procedures – Sign & Date 1. Agency Safety a. Fire Prevention and plan b. Smoke sensors c. Fire Extinguishers d. Exit Signs e. Security f. Tornado Plan g. Emergency Preparedness - Dental Clinic Disaster Training - Management Support Disaster Assistance - Emergency Shelters and Team Assigned - Review Dental Clinic Chart Retention & Release		
2. Personal Safety a. Agency Worksite b. Vehicle Safety c. Threatening Behavior d. Medical Emergencies - Clients - Employees - Staff training for: * HIPAA * Cultural Diversity * Infection Control		

3. Infection Control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and Handling Supplies g. Standard Precautions h. Blood borne Pathogens i. Vaccinations * TB Skin Test * Hepatitis B or Waiver * Rubella * Tetanus * Influenza * Varicella j. Equipment Management * Vaccine transporting * Handling & Storage k. Identifying, Handling and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment * Gloves * Impermeable Gown * Antibacterial Hand Wash * Spill Kit * N-95-Respirator Mask * Goggles/Face Shield		
4. Community Resources and Collaboration		
5. Continuing Education Requirements		
6. Employee Performance Evaluation		
C. Improving Organizational Performance Measures 1. IOP Committee and Purpose 2. Call supervisor 1 hour prior to start time if not reporting to work 3. Job Description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Audits c. Incident Reports d. Bloodbourne Pathogen Exposures e. Client Complaints		
D. Preceptor Assigned – works with and under Directions of preceptor		
E. Orientation Period – write in dates (one month)		
F. Program Area		

1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable) 4. Pager System 5. Scope of services and program policy review 6. Service/Program Record a. Documentation system b. Documentation of medical record data and encounter forms		
G. Dental Clinic Support Staff performance of duties: 1. Reviews expectations of the assigned role. 2. Reviews state, local agency guidelines for assigned role if applicable.		
H. Expectations of the Management Support Staff Role * Report to work-site as assigned in a timely manner * Use appropriate communication skills * Document and enter data appropriately * Accounts for all work hours through sign-out sheets, leave records, time sheets and mileage sheets. * Reviews and updates job description annually * Adheres to dress code– displaying a professional appearance or worksite appropriate attire * Provides management support services to clients according to standards, program guidelines and collaborates with other health department staff or community resources * Treats Public with courtesy, & respect * Maintains complete confidentiality of client information – where applicable.		

Comments:

_____

_____

_____

_____

*When completed the supervisor needs to submit to the Personnel Technician for filing.

*The Orientation Checklist should be completed at the end of the employee's probationary status.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Date Developed: 06/23
Reviewed: 6/24
Revised:

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Mobile Dental Unit Staff

Competency Skills Checklist

		SUBJECT	DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Mobile Dental Unit (MDU) Staff applies theoretical concepts in practice.						
	B.	The MDU Staff work under direct supervisor of the dentist to assist with the following.						
	C.	The MDU Staff systematically collects data that is comprehensive and accurate.						
	D.	The MDU Staff observes, and records any reactions to treatment or changes in the client's condition.						
	E.	The MDU Staff intervenes to promote, maintain or restore health, to prevent illness, to minimize complications and effect rehabilitation.						
	F.	The MDU Staff evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	G.	The MDU Staff may participate in peer review and program audits to assure quality of services.						
	H.	The MDU Staff collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	I.	The MDU Staff reports to clinic as assigned in a timely manner.						
	J.	The MDU Staff introduces self to client.						
	K.	The MDU Staff uses appropriate communication techniques to make client comfortable, addresses client concerns and telephone calls with dignity and respect.						
	L.	The MDU Staff performs the work-up of clients, accurately documenting results of information obtained.						
	M.	MDU Staff facilitates the flow of clients through the clinic to promote health care accessibility, decrease wait time, and provide high quality services.						
	N.	MDU Staff demonstrates familiarity with the client record and chart composition.						
	O.	MDU Staff effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	P.	MDU Staff demonstrates support of agency by involvement in community activities.						
	Q.	MDU Staff uses chain of command for problem resolution.						
	R.	MDU Staff adheres to appropriate dress and grooming.						
	S.	MDU Staff maintains a reliable attendance record.						
	T.	MDU Staff safely and accurately assists other staff during procedures.						

	U.	The MDU Staff will thoroughly demonstrate assistance with: 1. Promotion and maintenance of health 2. Prevention of illness and disability 3. Diagnosing, treating and managing acute and chronic illnesses 4. Guidance and counseling for both individuals and families 5. Administering therapeutic measures, tests, procedures, drugs 6. Evaluating health outcomes 7. Quality Improvement for Dental Clinic Staff a. The Dental Clinic Staff will follow a written plan that has been devised by the dentist for evaluating the quality of care b. This plan will be documented identifying clinical problems, progress toward improving outcomes and recommendations for changes in treatment plan.						
	V.	Accurately records ICD-CDT Codes according to chief complaint and procedure performed.						
	W.	Accurately records daily client encounter.						
	X.	Documentation must be timely, accurate and precise.						
	Y.	Maintain licensure and continuing education requirements.						
	Z.	Adheres to agency policies and procedures - reviews annually						
	AA.	Reports any changes in client status.						
	BB.	Demonstrates ongoing communication with the client and professional staff.						
	CC.	Properly completes all required documentation on assigned clients within a timely manner using correct medical terminology.						
	DD.	Knowledgeable and maintains client rights and confidentiality.						
	EE.	Implements measures to maintain client confidentiality.						
	FF.	Demonstrates understanding and implementation of HIPAA compliance.						
	GG.	Provide empathic care for all clients including members of diverse and vulnerable populations						
	HH.	Apply the principles of jurisprudence to the practice of dentistry.						
	II.	Continuously analyze the outcomes of client treatment to improve that treatment						
	JJ.	Assess his or her level of skills and knowledge and take steps to improve areas of deficiency						
	KK.	Evaluate social and economic trends and their impact on oral health care						
	LL.	Assist with the activity of allied dental health						
	MM.	Maintain client records						
	NN.	Use business systems in dental practice settings for scheduling, recordkeeping, reimbursement, and financial arrangements.						
	OO.	Control infection with environmental safety programs according to current standards						
	PP.	Practice within the scope of one's competence and make referrals to professional colleagues.						
	QQ.	Use information technology and information management systems for client care, practice management, and professional development.						

	RR.	Assess client goals values and concerns to establish rapport and guide client care.								
	SS.	Communicate orally, and in writing, with peers, other professionals, staff, clients or guardians and the public at large.								
	TT.	Participate in improving the oral health of individuals, families, and groups in the community through diagnosis, treatment, and education.								
	UU.	Recognize predisposing and etiologic factors that require intervention to prevent disease.								
	VV.	Report of clinical findings and significant deviations that require monitoring treatment or management to the dentist,								
	WW.	Provide clinical radiographic and other diagnostic information and procedures								
	XX.	Obtain medical and dental consultations when appropriate with the dentist.								
	YY.	Educate clients so they can participate in the management of their own care.								
	ZZ.	Treatment plan that incorporates client's goals, values and concerns								
	AAA	Obtain informed consent from client, parent or guardian								
	BBB	Follow initial treatment and follow-up management for medical emergencies that may occur during dental treatment.								
	CCC	Perform basic cardiac life support								
	DDD	Recognize and manage acute pain, hemorrhage, trauma, and infection of the orofacial complex.								
	EEE	Manage client with pain and anxiety by the use of nonpharmacological methods.								
	FFF	Anticipate, prevent, and manage complications arising from the use of therapeutic and pharmacological agents employed in client care.								
	GGG	Provide client education to maximize oral health								
	HHH	Manage preventive oral health procedures								
	III	Assist with therapies to eliminate local etiology factors to control caries, periodontal disease, and other oral diseases								
	JJJ	Assist clients with advanced periodontal diseases and conditions								
	KKK	Assist clients with pulpal and periradicular diseases.								
	LLL	Assist with uncomplicated endodontic procedures								
	MMM.	Assist with uncomplicated oral surgical procedures								
	NNN	Assist clients who have complicated oral surgical problems								
	OOO	Assist clients requiring modification of oral tissues to optimize restorations of form, function and esthetics								
	PPP	Assist clients who have complex orthodontic problems								
	QQQ	Assist with restoring single defective teeth								
	RRR	Restore partial or completed edentulism with uncomplicated fixed or removable prosthetic restorations.								
	SSS	Manage the restoration of partial or complete edentulism using implant procedures								
	TTT	Assist client with oral esthetic needs								
II.	**Infection Control Measures:**									
		1.	**Handwashing** Washes hands at least 30 seconds under running water.							

		2.	Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.						
		3.	Keep fingers pointed down, lower than wrists to prevent contamination of the arms.						
		4.	Rinse hands under running water allowing water to flow from the upper arm down over the hands.						
		5.	Dry hands thoroughly with a dry paper towel.						
		6.	Use a separate paper towel to turn off the faucet.						
		7.	Use lotion to prevent drying of the skin.						
		8.	Cleanse hands with a 60% alcohol based hand sanitizer. Cover all surfaces of hands with product and rub until dry.						
	A.	Disposal of soiled materials							
	B.	Disposal of excretions							
	C.	Universal Precautions							
	D	Has attended initial training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.							
	E.	Demonstrates an understanding of and practices universal precautions.							
	F.	Demonstrates an understanding of modes of transmission of bloodborne diseases.							
	G.	Demonstrates knowledge and selection of personal protective equipment.							
	H.	Practices handwashing to prevent spread of disease.							
	I.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.							
			Standard Precautions						
		1.	Explain procedure						
		2.	Assemble equipment						
		3.	Wash hands						
		4.	Uses protective barrier precautions (mask, protective eyewear, gowns, gloves) as appropriate to prevent contact with client's body/blood fluids.						
		5.	Disposes of all needles/sharps in appropriate container. Fills sharps container only to 2/3 capacity.						
		6.	Secures lid on capacity filled container and places container on shelf in lab work-up room for disposal.						
		7.	Disposes of soiled material properly.						
		8.	Knows location of and usage for spill kit.						
		9.	Cleans equipment (stethoscope, blood pressure cuff) with alcohol wipe after each client usage. Cleans equipment weekly with Gavicide solution.						
		10.	Keeps one-way air resuscitation mask in emergency cart. Can demonstrate proper usage.						
III.	**Skills Performance:**								
	A.	Sitting:							
		1.	Position buttocks against the back of chair.						
		2.	Place feet flat on floor at 90 degree angle to lower legs.						
		3.	Flexes hip slightly so knees are higher than ischial tuberosities.						
		4.	Flexes lumbar spine slightly.						
		5.	Flexes elbows and places forearms on armrest, if applicable.						
	B.	Standing:							

		1.	Keeps feet parallel 6 inches to 8 inches apart.							
		2.	Places equal weight on both legs.							
		3.	Flexes knees slightly.							
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.							
	C.	Walking:								
		1.	Assumes the correct standing position.							
		2.	Steps forward a comfortable distance with one leg.							
		3.	Tilts the pelvis slightly forward and downward.							
		4.	Touches floor first with heel then ball of foot to toes.							
		5.	Advances the other arm and leg to promote balance.							
	D.	Pulling:								
		1.	Stands close to the object.							
		2.	Places one foot slightly ahead of the other.							
		3.	Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscle.							
	E.	Pushing:								
		1.	Places hands on object and flexes the elbows.							
		2.	Leans into the object by shifting weight from back leg to front leg.							
		3.	Applies smooth continuous pressure.							
	F.	Stooping:								
		1.	Stands with feet 10-13 inches apart.							
		2.	Places one foot slightly ahead of the other.							
		3.	Lowers self by flexing the knees.							
		4.	Places more weight on front foot than back.							
		5.	Keeps upper body straight (does not bend at the waist).							
		6.	Straightens knees keeping the back straight.							
	G.	Lifting and Carrying:								
		1.	Assumes stooping position directly in front of the object.							
		2.	Grasps object and tightens abdominal muscles.							
		3.	Stands up straight by straightening the knees.							
		4.	Carries the object close to the body waist high.							

_____ successfully demonstrates the above criteria in the clinical setting.

_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date

Developed: 06/23
Reviewed: 6/24
Revised:

The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Dentist

Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Dentist applies theoretical concepts in practice.						
	B.	The Dentist systematically collects data that is comprehensive and accurate.						
	C.	The Dentist observes, and records any reactions to treatment or changes in the client's condition.						
	D.	The Dentist intervenes to promote, maintain or restore health, to prevent illness, to minimize complications and effect rehabilitation.						
	E.	The Dentist evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	F.	The Dentist may participate in peer review and program audits to assure quality of services.						
	G.	The Dentist collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	H.	The Dentist reports to mobile dental unit as assigned in a timely manner.						
	I.	The Dentist introduces self to client.						
	J.	The Dentist uses appropriate communication techniques to make client comfortable, addresses client concerns and telephone calls with dignity and respect.						
	K.	The Dentist performs the work-up of clients, accurately documenting results of information obtained.						
	L.	Dentist facilitates the flow of clients through the clinic to promote health care accessibility, decrease wait time, and provide high quality services.						
	M.	Dentist demonstrates familiarity with the client record and chart composition.						
	N.	Dentist effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	O.	Dentist demonstrates support of agency by involvement in community activities.						
	P.	Dentist uses chain of command for problem resolution.						
	Q.	Dentist adheres to appropriate dress and grooming.						
	R.	Dentist maintains a reliable attendance record.						
	S.	Dentist safely and accurately assists other staff during procedures.						
	T.	The Dentist will thoroughly demonstrate: 1. Promotion and maintenance of health 2. Prevention of illness and disability 3. Diagnosing, treating and managing acute and chronic illnesses						

		4. Guidance and counseling for both individuals and families 5. Prescribing, administering and dispensing therapeutic measures, tests, procedures, drugs 6. Evaluating health outcomes 7. Quality Improvement for Dentist a. The Dentist will establish a written plan that for evaluating the quality of care b. This plan will be documented identifying clinical problems, progress toward improving outcomes and recommendations for changes in treatment plan.						
	U.	Accurately records ICD-CDT Codes according to chief complaint and procedure performed.						
	V.	Accurately records daily client encounter.						
	W.	Documentation must be timely, accurate and precise.						
	X.	Maintain licensure and continuing education requirements.						
	Y.	Adheres to agency policies and procedures - reviews annually						
	Z.	Reports any changes in client status.						
	AA.	Demonstrates ongoing communication with the client and professional staff.						
	BB.	Properly completes all required documentation on assigned clients within a timely manner using correct medical terminology.						
	CC.	Knowledgeable and maintains client rights and confidentiality.						
	DD.	Implements measures to maintain client confidentiality.						
	EE.	Demonstrates understanding and implementation of HIPAA compliance.						
	FF.	Apply ethical principles to professional practice.						
	GG.	Provide empathic care for all clients including members of diverse and vulnerable populations						
	HH.	Apply the principles of jurisprudence to the practice of dentistry						
	II.	Continuously analyze the outcomes of client treatment to improve that treatment						
	JJ.	Evaluate scientific literature and other sources of information to make decisions about dental treatment						
	KK.	Manage oral health based on an application of scientific principles						
	LL.	Participate in professional organizations						
	MM.	Assess his or her level of skill and knowledge and take steps to improve areas of deficiency						
	NN.	Evaluate social and economic trends and their impact on oral health care						
	OO.	Evaluate career options, practice locations and reimbursement mechanisms						
	PP.	Educate staff in professional, governmental, legal and office policies and professional responsibilities						
	QQ.	Coordinate and supervise the activity of allied dental health personnel						
	RR.	Maintain Client records						
	SS.	Use business systems in dental practice settings for scheduling, record keeping, reimbursement and financial arrangements.						
	TT.	Implement and monitor infection control and environmental safety programs according to current standards.						
	UU.	Practice within the scope of one's competence and make referrals to professional colleagues.						

	VV.	Use information technology and information management systems for client care, practice management and professional development.						
	WW.	Assess client goals, values, and concerns to establish rapport and guide client care.						
	XX.	Communicate orally, and in writing, with peers, other professionals, staff, client or guardians and the public at large						
	YY.	Participate in improving the oral health of individual families and groups in the community through diagnosis treatment and education.						
	ZZ.	Recognize predisposing and etiologic factors that require intervention to prevent disease						
	AAA.	Use clinical and epidemiological data to diagnose and establish a prognosis for dental abnormalities and pathology						
	BBB.	Recognize the normal range of clinical findings and significant deviations that require monitoring, treatment or management						
	CCC.	Monitor therapeutic outcomes and re-evaluate and modify initial diagnosis or therapy						
	DDD.	Develop treatment and alternatives based on clinical and supporting data						
	EEE.	Select, obtain, and interpret clinical , radiographic and other diagnostic information and procedures						
	FFF.	Obtain medical and dental consultations when appropriate						
	GGG.	Integrate multiple disciplines into an individual comprehensive sequenced treatment plan using diagnostic and prognostic information						
	HHH.	Discuss etiologies, treatment alternatives, and prognoses with clients and educate them so they can participate in the management of their own care						
	III.	Develop and implement a sequenced treatment plan that incorporates patient's goals, values and concerns						
	JJJ.	Obtain informed consent from client, parent or guardian						
	KKK.	Anticipate, diagnosis, and provide initial treatment and follow-up management for medical emergencies that may occur during dental treatment						
	LLL.	Perform basic cardiac life support						
	MMM	Recognize and manage acute pain, hemorrhage, trauma and infection of the orofacial complex						
	NNN.	Manage clients with pain and anxiety by the use of nonpharmacological methods						
	OOO.	Select and administer or prescribe pharmacological agent in the treatment of dental clients						
	PPP.	Anticipate prevent and manage complications arising from the use of therapeutic and pharmacological agents employed in client care.						
	QQQ.	Provide patient education to maximize oral health						
	RRR.	Manage preventive oral health procedures						
	SSS.	Perform therapies to eliminate local etiologic factors to control caries, periodontal disease, and other oral diseases						
	TTT.	Manage clients with advanced periodontal diseases and conditions						
	UUU.	Manage clients with pulpal and periradicular disease						
	VVV.	Perform uncomplicated endodontic procedures						
	WWW	Perform uncomplicated oral surgical procedures						
	XXX.	Manage clients who have complicated oral surgical problems						

	YYY.	Manage clients requiring modification of oral tissues to optimize restoration of form function and esthetics							
	ZZZ.	Manage clients with occlusal and temporomandibular disorders							
		Manage a comprehensive maintenance plan following the active phase of periodontal treatment							
		Manage clients requiring minor tooth movement or space maintenance							
		Manage clients who have complex orthodontic problems.							
		Restore single defective teeth							
		Restore partial or complete edentulism with uncomplicated fixed or removable prosthetic restorations							
		Manage the restoration of partial or complete edentulism using implant procedure.							
		Manage clients with oral esthetic needs							
		Communicate case design with laboratory technicians and evaluate the resultants prosthesis							
II.	**Infection Control Measures:**								
		Handwashing							
		1. Washes hands at least 30 seconds under running water.							
		2. Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.							
		3. Keep fingers pointed down, lower than wrists to prevent contamination of the arms.							
		4. Rinse hands under running water allowing water to flow from the upper arm down over the hands.							
		5. Dry hands thoroughly with a dry paper towel.							
		6. Use a separate paper towel to turn off the faucet.							
		7. Use lotion to prevent drying of the skin.							
		8. Cleanse hands with a 60% alcohol based hand sanitizer. Cover all surfaces of hands with product and rub until dry.							
	A.	Disposal of soiled materials							
	B.	Disposal of excretions							
	C.	Universal Precautions							
	D	Has attended initial training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.							
	E.	Demonstrates an understanding of and practices universal precautions.							
	F.	Demonstrates an understanding of modes of transmission of bloodborne diseases.							
	G.	Demonstrates knowledge and selection of personal protective equipment.							
	H.	Practices handwashing to prevent spread of disease.							
	I.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.							
		Standard Precautions							
		1. Explain procedure							
		2. Assemble equipment							
		3. Wash hands							
		4. Uses protective barrier precautions (mask, protective eyewear, gowns, gloves) as appropriate to prevent contact with client's body/blood fluids.							
		5. Disposes of all needles/sharps in appropriate container.							

		6.	Fills sharps container only to 2/3 capacity. Secures lid on capacity filled container and places container on shelf in lab work-up room for disposal.						
		7.	Disposes of soiled material properly.						
		8.	Knows location of and usage for spill kit.						
		9.	Cleans equipment (stethoscope, blood pressure cuff) with alcohol wipe after each client usage. Cleans equipment weekly with Gavicide solution.						
		10.	Keeps one-way air resuscitation mask in emergency cart. Can demonstrate proper usage.						
III.	**Skills Performance:**								
	A.		Sitting:						
		1.	Position buttocks against the back of chair.						
		2.	Place feet flat on floor at 90 degree angle to lower legs.						
		3.	Flexes hip slightly so knees are higher than ischial tuberosities.						
		4.	Flexes lumbar spine slightly.						
		5.	Flexes elbows and places forearms on armrest, if applicable.						
	B.		Standing:						
		1.	Keeps feet parallel 6 inches to 8 inches apart.						
		2.	Places equal weight on both legs.						
		3.	Flexes knees slightly.						
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.						
	C.		Walking:						
		1.	Assumes the correct standing position.						
		2.	Steps forward a comfortable distance with one leg.						
		3.	Tilts the pelvis slightly forward and downward.						
		4.	Touches floor first with heel then ball of foot to toes.						
		5.	Advances the other arm and leg to promote balance.						
	D.		Pulling:						
		1.	Stands close to the object.						
		2.	Places one foot slightly ahead of the other.						
		3.	Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttocks muscle.						
	E.		Pushing:						
		1.	Places hands on object and flexes the elbows.						
		2.	Leans into the object by shifting weight from back leg to front leg.						
		3.	Applies smooth continuous pressure.						
	F.		Stooping:						
		1.	Stands with feet 10-13 inches apart.						
		2.	Places one foot slightly ahead of the other.						
		3.	Lowers self by flexing the knees.						
		4.	Places more weight on front foot than back.						
		5.	Keeps upper body straight (does not bend at the waist).						
		6.	Straightens knees keeping the back straight.						
	G.		Lifting and Carrying:						
		1.	Assumes stooping position directly in front of the object.						
		2.	Grasps object and tightens abdominal muscles.						
		3.	Stands up straight by straightening the knees.						
		4.	Carries the object close to the body waist high.						

_____ successfully demonstrates the above criteria in the clinical setting.

_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date

Developed: 06/23
Reviewed: 6/24
Revised:

The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Mobile Dental Unit Management Support Staff

Competency Skills Checklist

SUBJECT			DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Management Support Staff applies theoretical concepts in practice.						
	B.	The Management Support Staff systematically collects and completes data that is comprehensive and accurate.						
	C.	The Management Support Staff may assist in analyzing data about the community, family and individual.						
	D.	The Management Support Staff in collaboration with the Dental Staff strives to promote, maintain or restore health, to prevent illness, to minimize complications and effect rehabilitation.						
	E.	The Management Support Staff in collaboration with the Dental Staff evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	F.	The Management Support Staff may participate in peer review and program audits to assure quality of services.						
	G.	The Management Support Staff collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	H.	The Management Support Staff reports to work station as assigned in a timely manner.						
	I.	The Management Support Staff introduces self to client, when interacting with client services.						
	J.	The Management Support Staff uses appropriate communication techniques to make client comfortable, addresses client concerns and telephone calls with dignity and respect.						
	K.	The Management Support Staff may facilitate the flow of clients through the clinic to promote dental care accessibility decrease wait time and provide high quality services.						
	L.	Management Support Staff may demonstrate familiarity with the client record and chart composition.						
	M.	Management Support Staff effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	N.	Management Support Staff demonstrates support of agency by involvement in community activities.						
	O.	Management Support Staff uses chain of command for problem resolution.						
	P.	Management Support Staff adheres to appropriate dress and grooming.						

	Q.	Management Support Staff maintains a reliable attendance record.						
	R	Management Support Staff demonstrates competency in accurately filing of dental records.						
	S.	Management Support Staff demonstrates thorough knowledge of daily operation of the computer system.						
	T.	The Management Support Staff demonstrates accurate participation in their role of the billing cycle. 1. Data Entry for encounters 2. Data Entry /actual billing procedures						
	U.	Management Support Staff demonstrates thorough knowledge of typing skills, maintaining proficiency and timely manner.						
	V.	Management Support Staff demonstrates thorough knowledge of medical terminology and spelling.						
	W.	Management Support Staff demonstrates proficiency in general office procedures.						
	X.	Management Support Staff demonstrates ability to retrieve statistical information as needed.						
	Y.	Management Support Staff demonstrates thorough understanding of mail process and distribution services.						
	Z	Management Support Staff adheres to agencies policies and procedures – reviews annually.						
	AA.	Management Support Staff properly completes all required documentation on assigned clients within a timely manner using correct medical terminology.						
	BB.	Management Support Staff is knowledgeable and maintains client rights and confidentiality						
	CC.	Management Support Staff implements measures to maintain client confidentiality.						
	DD.	Management Support Staff demonstrates understanding and implementation of HIPAA compliance.						
II.		**Infection Control Measures:**						
		Hand washing 1. Washes hands at least 30 seconds under running water. 2. Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap. 3. Keep fingers pointed down; lower than wrists to prevent contamination of the arms. 4. Rinse hands under running water allowing water to flow from the upper arm down over the hands. 5. Dry hands thoroughly with a dry paper towel. 6. Use a separate paper towel to turn off the faucet. 7. Use lotion to prevent drying of the skin. 8. Cleanse hands with a 60% alcohol based hand sanitizer. Cover all surfaces of hands with product and rub until dry.						
	A.	Disposal of soiled materials						
	B.	Disposal of excretions						
	C.	Universal Precautions						
	D	Has attended annual training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.						
	E.	Demonstrates an understanding of and practices universal precautions.						

	F.	Demonstrates an understanding of modes of transmission of blood borne diseases.							
	G.	Demonstrates knowledge and selection of personal protective equipment.							
	H.	Practices hand washing to prevent spread of disease.							
	I.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.							
		Standard Precautions							
		1. Assemble equipment							
		2. Wash hands							
		3. Uses protective barrier precautions (mask, protective eyewear, gowns, and gloves) as appropriate to prevent contact with client's body/blood fluids.							
		4. Disposes of all needles/sharps in appropriate container. Fills sharps container only to 2/3 capacity.							
		5. Secures lid on capacity filled container and places container on shelf in lab work-up room for disposal.							
		6. Disposes of soiled linen properly.							
		7. Knows location of and usage for spill kit. Nursing home visiting staff keeps spill kit in their car.							
III.	**Skills Performance:**								
	A.	Sitting:							
		1. Position buttocks against the back of chair.							
		2. Place feet flat on floor at 90 degree angle to lower legs.							
		3. Flexes hip slightly so knees are higher than ischial tuberosities.							
		4. Flexes lumbar spine slightly.							
		5. Flexes elbows and places forearms on armrest, if applicable.							
	B.	Standing:							
		1. Keeps feet parallel 6 inches to 8 inches apart.							
		2. Places equal weight on both legs.							
		3. Flexes knees slightly.							
		4. Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.							
	C.	Walking:							
		1. Assumes the correct standing position.							
		2. Steps forward a comfortable distance with one leg.							
		3. Tilts the pelvis slightly forward and downward.							
		4. Touches floor first with heel then ball of foot to toes.							
		5. Advances the other arm and leg to promote balance.							
	D.	Pulling:							
		1. Stands close to the object.							
		2. Places one foot slightly ahead of the other.							
		3. Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscle.							
	E.	Pushing:							
		1. Places hands on object and flexes the elbows.							
		2. Leans into the object by shifting weight from back leg to front leg.							
		3. Applies smooth continuous pressure.							
	F.	Stooping:							
		1. Stands with feet 10-13 inches apart.							

		2.	Places one foot slightly ahead of the other.							
		3.	Lowers self by flexing the knees.							
		4.	Places more weight on front foot than back.							
		5.	Keeps upper body straight (does not bend at the waist).							
		6.	Straightens knees keeping the back straight.							
	G.	Lifting and Carrying:								
		1.	Assumes stooping position directly in front of the object.							
		2.	Grasps object and tightens abdominal muscles.							
		3.	Stands up straight by straightening the knees.							
		4.	Carries the object close to the body waist high.							

_____ successfully demonstrates the above criteria in the work setting.

_____ _____

Employee Signature & Date Reviewer's Initials & Date

_____ _____

Employee Signature & Date Reviewer's Initials & Date

_____ _____

Employee Signature & Date Reviewer's Initials & Date

Developed: 06/23
Reviewed: 6/24
Revised:

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

NURSING POLICIES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NURSING DEPARTMENT PHILOSOPHY

DATE DEVELOPED: 8/8/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services strives hard to provide the citizens of Rockingham County with professional nursing services in a variety of clinic settings.

II. PURPOSE:

A. To promote professional services.

B. To establish standards of nursing services.

III. GUIDELINES:

A. The Nursing Section of the Division of Public Health Services is proud of the services we offer and of the way we offer them. New employees are quickly oriented to our philosophy of serving as client advocate and community servant with a high regard for humanity as a whole.

B. As a Division, we realize that today's changing society can place individuals and families in vulnerable and sometimes precarious positions. We empathize with these positions and understand that they may make it necessary for individuals and families to avail themselves of our services, which are at times literally lifesaving.

C. In order to address the needs of our community's population, we strive to keep our services up to date and pertinent. It is our intention to ensure that our personnel are trained in the latest procedures and that they acquire and maintain the most up to date nursing skills.

D. We take pride in the fact that our nursing services are an integral part of total service to the client. Our clients receive not only our nursing services, but the services of other professions in our department and our community when needed to ensure a continuum of quality care.

E. It is our goal to never place ourselves, either as individuals or as an agency program, above the needs of the clients we serve. It is our goal to never offer our services in a way that is demeaning to our clients or in a way that otherwise makes our clients uncomfortable. We try to always be aware that very little separates us as nurses from the vulnerable positions many of our clients find themselves experiencing. We strive to treat all clients as we ourselves would like to be treated.

F. We are committed to continued personal, professional and agency growth to meet the needs of our community. We happily accept our role in the community as a leader for education and referral.

G. We would like any member of our community, regardless of their community standing, to feel comfortable seeking our services and to feel confident that the care they receive is the finest care available.

Public Health

Definition - Public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences.

Public health nursing practice is a systematic process by which:

1. The health and health care needs of a population are assessed in order to identify sub-populations, families, and individuals who would benefit from health promotion or who are at risk of illness, injury, disability, or premature death.

2. A plan for intervention is developed within the community to meet identified needs that take into account available resources, the range of activities that contribute to health and the prevention of illness, injury, disability, and premature death.

3. The plan is implemented effectively, efficiently, and equitably.

4. Evaluations are conducted to determine the extent to which the interventions have an impact on the health status of individuals and the population.

5. The results of the process are used to influence and direct the current delivery of care, deployment of health resources, and the development of local, regional, state, and national health policy and research to promote health and prevent disease.

This systematic process is based on and is consistent with:

1) Community strengths, needs and expectations;
2) Current scientific knowledge;
3) Available resources;
4) Accepted criteria and standards of nursing practice;
5) Agency purpose, philosophy and objectives; and
6) The participation, cooperation, an understanding of the population. Other services and organizations in the community are considered and planning is coordinated to maximize the effective use of resources and enhance outcomes.

The title "public health nurse" designates a nursing professional with educational preparation in public health and nursing science with a primary focus on population-level outcomes. The primary focus of public health nursing is to promote health and prevent disease for entire population groups. This may include assisting and providing care to individual members of the population. It also includes the identification of individuals who may not request care but who have health problems that put themselves and others in the community at risk, such as those with infectious diseases. The focus of public health nursing is not on providing direct care to individuals in community settings. Public health nurses support the provision of direct care through a process of evaluation and assessment of the needs of individuals in the context of their population group. Public health nurses work with other providers of care to plan and develop more support systems and programs in the community to prevent problems and provide access to care.

The Role of Public Health Nurses

Public health nurses integrate community involvement and knowledge about the entire population with personal, clinical understandings of the health and illness experiences of individuals and families within the population. They translate and articulate the health and illness experiences of diverse, often vulnerable individuals and families in the population to health planners and policy makers, and assist members of the community to voice their problems and aspirations. Public health nurses are knowledgeable about multiple strategies for intervention, from those applicable to the entire population, to those for the family, and the individual.

Public health nurses translate knowledge from the health and social sciences to individual and population groups through targeted interventions, programs, and advocacy.

Public health nursing may be practiced by one public health nurse or by a group of public health nurses working collaboratively. In both instances, public health nurses are directly engaged in the inter-disciplinary activities of the core public health functions of assessment, assurance and policy development. Interventions or strategies may be targeted to multiple levels depending on where the most effective outcomes are possible. They include strategies aimed at entire population groups, families, or individuals. In any setting, the role of public health nurses focuses on the prevention of illness, injury or disability, the promotion of health, and maintenance of the health of populations.

References:

Stanhope, M. and Lancaster J., (2008). Public Health Nursing. 7th Edition, Missouri, Mosby & Elsner

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SCOPE OF SERVICES

DATE DEVELOPED: 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/24

I. POLICY:

The Division of Public Health Services provides services to individuals and families in the clinic setting, community and in the home. Care is provided by RN, LPN, Advanced Practice Provider (APP), Social Worker, Pharmacist, Lab Technician, Medical Office Assistant, Management Support staff, and WIC staff.

II. PURPOSE:

A. To provide services in accordance with state and federal laws and regulations.

B. To provide standards of high quality client care.

C. To promote good professional relationships between all health and social agencies and physicians.

D. To insure that all staff engage only in those activities which are recognized to constitute approved practice.

III. GUIDELINES:

A. Services defined herein will be offered Monday through Friday with the exception of holidays approved by Rockingham County. The office will be staffed during the hours of 8:00 a.m. till 5:00 p.m. After hours, holidays and weekends will be scheduled by staff when medically necessary on an on-call basis. After hours, holidays and weekends, staff will be on-call in adult health and child health for clients assigned to the Division of Public Health Services with Carolina Access.

B. The Division of Public Health Services also **provides** night clinic on Thursday nights from 5:00 – **8:00 p.m**. The programs that provide a Thursday night include:

1. Pediatric Primary Care; Immunization, Adult Health, Child Health
2. Family Planning Services
3. Lab

4. Pharmacy
5. WIC (5:00 – 7:30 p.m.)

C. The Division of Public Health Services provides community outreach services through Health Fairs and staff speaking opportunities for community partners and organizations. These Health Fairs may be conducted during normal work hours or on the weekend.

D. The Division of Public Health Services serves clients of Rockingham County for communicable disease.

E. All services are supervised by professional personnel and are delivered in accordance with all applicable occupation practice acts.

F. Title VI of the Civil Rights Act will be complied with under all circumstances regarding acceptance of clients and care of clients.

G. All services are provided in accordance with a plan of care developed in conjunction with the client/caregiver and consistent with the orders of the client's licensed physician, or the agency's physician extender. This plan of care is individualized to meet the client's needs.

H. If the determination is made to discharge or transfer the client, the client will be given notification of same, verbally and in writing, and the agency will allow for a thirty-day transitional period depending upon specifics of the case to facilitate a continuum of care.

In each case that is determined the agency cannot service the client, documentation must be made and placed in the electronic health record (EHR). The Medical Director and Director of Nursing may also be consulted for advisement.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: STANDARDS OF PRACTICE

DATE DEVELOPED: 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

Services/care provided by the Division of Public Health Services is provided in accordance with accepted standards of practice, in accordance with physician/ Advanced Practice Provider (APP) orders and is directed toward the achievement of optimal patient outcomes.

II. PURPOSE:

To establish the standards for the provision of health care services provided by the Division of Public Health Services.

III. GUIDELINES:

A. Health care services are provided in accordance with applicable national, state and organizational standards of practice. These include but are not limited to:

1. North Carolina occupation practice acts.
   - American Heart Association
   - NC Board of Nursing
   - Nursing Practice Act
   - Social Work Certification Act
   - Board of Pharmacy
   - NC Medical Board
   - CLIA Regulations
   - Dentistry
2. Standards of practice adopted by national and state health professional associations including but not limited to:
   - CDC
   - OSHA Regulations
   - NC Health and Human Resources
   - NC and American Speech and Hearing Association

B. All health care services provided are directed toward the achievement of optimal patient outcomes and are periodically evaluated to determine the achievement of those outcomes.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PHYSICIAN ORDERS

DATE DEVELOPED: 11/90
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/22; 6/23; 6/24

I. POLICY:

All health services are provided in accordance with physician individual orders.

II. PURPOSE:

A. To meet regulatory and reimbursement requirements.

B. To facilitate quality and risk management in the receipt of physician telephone orders.

C. To provide maximum safety standards in the receipt of physician telephone orders.

D. To enhance professional clarification of physician telephone orders.

III. GUIDELINES:

A. Physician orders are accepted directly from a physician, a designated representative acting on behalf of the physician by a licensed health care professional.

B. Physician orders may be transmitted in one of several ways, including:

1. Telephone orders.

2. Verbal orders from the physician.

3. Orders written on the physician's prescription pad.

4. Facsimile transmission.

C. Verbal medical orders from the client or family will not be accepted by agency unless verified by a RN, LPN, or Advanced Practice Provider (APP) with the physician.

D. When appropriate, orders will be requested to teach the family or other responsible person(s) appropriately delegated health care techniques.

E. Drugs and treatments are administered only as ordered by a physician or APP.

F. The professional staff will notify the physician/APP of any changes in the client's condition, which indicates the need for altering the plan of care or termination of services. All contacts with the physician will be recorded in the client's clinical record.

G. The nurse who receives the telephone order completes the Division of Public Health Services' prescription pad, documenting:

1. The physician or designee giving the order
2. Client's name
3. Date order received
4. Specific order received
5. Signature of nurse receiving order
6. Physician may co-sign the prescription at MD night clinic.

H. **All telephone and verbal orders must be written on the day of the order.** The copy of the signed order is scanned into the client's electronic health record (EHR).

I. Physician's orders may be accepted by the client presenting the order on the physician prescription pad. Any questions surrounding the validity of these orders will be confirmed by contacting the physician by phone.

J. Facsimile orders with physician's signature and date will be accepted and scanned into the client's EHR. The TB program may transfer the order received by facsimile onto a prescription pad and follow procedures for physician telephone orders as stated in this policy.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISIOIN OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT RIGHTS AND RESPONSIBILITIES

DATE DEVELOPED: 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18; 6/22

I. POLICY:

A. To honor, promote, and inform clients of their rights and responsibilities in regard to participating in decisions regarding their care.

B. The agency representatives may review with client and/or family members, during the visit, their rights and responsibilities.

II. PURPOSE:

A. To protect and promote the exercise of clients' rights and responsibilities.

B. To ensure the ability of the Division of Public Health Services personnel to execute health care services in a safe environment.

C. To promote the formulation of a workable plan of care as pertinent information is gathered from the client or family.

D. To ensure that each client's civil and religious rights and liberties are protected without discrimination with regard to religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status.

III. GUIDELINES:

Clients may be given oral, electronic**,** and/or written information about his/her rights and responsibilities in that:

1. Interpretations are made available on a level that the client/family can understand in their native language or an interpreter as often as possible.

2. If the client cannot read, the health department professional staff or interpreter may discuss the rights and responsibilities with the client or family member.

3. Client liability for payment.

a. The client/family/caregiver will be advised whenever possible, before care is initiated, of the extent to which payment for the services may be expected from private pay source and the extent to which payment may be required from the client before service is initiated.

b. The client/family/caregiver will be advised orally and/or in writing of any changes in the information provided whenever possible as they occur during the visit.

4. Client will be informed of their responsibilities in the hands-on delivery of direct client care and written educational material will be given as it is available.

5. Clients are encouraged to voice health care concerns to the Division of Public Health Services staff as they develop. Clients are always supported in a courteous manner with their health care choices though the staff member may not be able to honor the client's decisions due to mission or scope of service guidelines. If issues cannot be resolved between the client and the Division of Public Health Services primary staff member, the client may contact the supervisor, Nursing Director, or Health Director to voice their concerns or complaints.

6. Each health care employee honors all clients' rights and is responsible for their implementation.

a. Services are provided voluntarily based upon the client's consent.
b. The health care staff involves the client in the development and any changes in the plan of care to the extent possible based on the client's ability and desire.
c. On-going documentation reflects involvement of the client in all decisions regarding his/her care.
d. At a minimum, staff clearly and consistently communicate information about care to be provided by the health care program, in a language that the client can reasonably be expected to understand, to include, but not limited to:

(1) Reason for any prescribed treatment.
(2) The nature and purpose of any technical procedure
(3) Potential benefit(s), risk(s) and effects of any procedure(s), their likelihood of success and problems related to recuperation.
(4) Who will perform procedures.

7. Client rights include the following, at a minimum:

   a. be informed and participate in the plan of care and treatment
   b. voice grievances about care and not be subject to discrimination or reprisal for doing so
   c. assurance of privacy and confidentiality of all information
   d. have all property treated with respect
   e. be informed of any liability/responsibility for payment
   f. program services are available without any prerequisites or coercions for other services.

8. Consent by a minor

   a. Under the general law, parents or other legal guardians control the medical treatment of minor children. However, N.C. does have a minor consent law (NCGS 90-21.5) that allows minors to consent to their own care for the prevention, diagnosis, and treatment of:

      - venereal disease and other diseases reportable under G.S. 130A-135
      - pregnancy
      - abuse of controlled substances or alcohol
      - emotional disturbance

   b. Any minor who is emancipated may consent to any medical treatment (dental and health services) for himself or for their child.

References: North Carolina General Statute 90-21.5
NCAC 36.0221
21 NCAC 36.0224

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NURSING SERVICES/ADVANCED PRACTICE PROVIDER (APP) – STANDARDS OF PRACTICE

DATE DEVELOPED: 3/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/18; 6/19

I. POLICY:

The Division of Public Health Services will follow the standards of nursing practice as set forth through the N.C. Board of Nursing – Nurse Practice Act, and North Carolina Medical Board.

II. PURPOSE:

To identify and establish acceptable standards of practice for the nursing staff and Advanced Practice Provider (APP) role.

III. GUIDELINES:

Registered Nurse:

A. The Registered Nurse is the licensed nurse accountable for the full scope of nursing practice.

B. The responsibilities and duties of the RN may vary depending on the clinical setting. There are variables that set the stage for the scope of nursing services to be provided.

These may include:

1. The nurse's basic educational preparation as well as any knowledge and skills acquired through continuing education and practice;
2. The complexity and frequency of nursing care needed by a given client population;
3. The qualifications and numbers of other staff;
4. The accessible resources.
5. Established policies, procedures, practices and channels of communication which lend support to the types of nursing services offered.

C. Nurses are responsible for:

1. Components of Practice for the Registered Nurse – taken from the North Carolina Nursing Practice Act.

2. Registered Nursing Accountability for Implementing a Treatment or Pharmaceutical Regimen. From Administrative Rule .0221 of the Nursing Practice Act.

   (See 21 NCAC 36.0221 and 21 NCAC 36.0224 Attached)

D. A current North Carolina License is required in order to practice nursing services.

1. The Director of Nursing verifies each nurse's license prior to hiring.

2. Each nurse is responsible for presenting the Staff Development Coordinator with a copy of their license upon renewal. Failure to keep license renewed – will result in a suspension of practicing nursing services.

3. The supervisors and the Director of Nursing will keep abreast on nursing revoked licenses and suspensions or denials of licensure through the North Carolina Board of Nursing. At any point a license is in question the Director of Nursing will contact the Board of Nursing for verification of current licensure.

<u>Licensed Practical Nurse</u>

E. The Licensed Practical Nurse performs delegated nursing activities. The responsibilities for performing delegated nursing activities which any LPN can safely accept are determined by the variables in each nursing practice setting. These include:

1. The LPN's own qualifications based on basic educational preparation as well as knowledge and skills acquired through continuing education and practice;

2. The degree of supervision by the RN;

3. The stability of each client's clinical condition;

4. The complexity and frequency of nursing care needed by each client or client group;

5. The accessible resources; and

6. Established policies, procedures, practices and channels of communication that lend support to the types of nursing services offered.

F. Components of Practice for the LPN: As taken from the North Carolina Nurse Practice Act.

1. Participating in assessment of the client's physical and mental health including the client's reaction to illnesses and treatment regimens;

2. Recording and reporting the results of the nursing assessments;

3. Participating in implementing the health care plan developed by the registered nurse and/or prescribed by any person authorized by State law to prescribe such a plan, by performing tasks assigned or delegated by and performed under the supervision or under orders or directions of a registered nurse, physician licensed to practice medicine, dentist, or other person authorized by State law to provide such supervision;

4. Assigning or delegating nursing interventions to other qualified personnel under the supervision of the registered nurse;

5. Participating in the teaching and counseling of clients as assigned by a registered nurse, physician or other qualified professional licensed to practice in North Carolina;

6. Reporting and recording the nursing care rendered and the client's response to that care.

7. Maintaining safe and effective nursing care, whether rendered directly or indirectly.

<u>Advanced Practice</u>

G. Nurse Practitioners/PAC – A legally protected title and the "approval to practice" must be obtained by The Board of Nursing and The Board of Medicine. Nurses are allowed to carry out orders signed by the APP.

Assignment of Duties: The nursing duties performed must be consistent with the parameters of nursing practice.

<u>Delegation of Functions</u>

H. Any task delegated is ultimately the responsibility of the person who delegates it.

I. The APP should always use nursing judgment and review four points before delegating anything:

1. Safety
2. Staffing
3. Schooling
4. Supervision

J. Tasks that may be delegated:

- Assessment may include collection of information for the health history, such as the assessment and treatment aspects under standing orders for the STD program. In addition, the Division of Public Health has indicated that the health history, as defined by programmatic standards is "assessment", i.e., it requires the use of judgment as to when additional questioning/clarification is needed and therefore, may NOT be delegated to unlicensed personnel.

- Development of an educational plan for a client does not preclude health educators from preparing and implementing educational programming for community groups on health promotion/disease prevention topics or even on specific diseases; however, only the APP may develop an individualized condition-specific educational plan for a specific client.

- Referrals must be reviewed by a licensed personnel to determine the approved plan of care to be determined by the treating APP (i.e., should a referral be received for a client the APP must review before any action is taken.)

<u>Delegation Requirements:</u>

K. RN Delegation to another RN or to a LPN; or Delegation to Nurse Aide - the Licensed Nurse retains responsibility and accountability for all delegated care (this includes making assignments).

L. The Licensed Nurse may delegate only those activities that are appropriate to the level of knowledge and skill of the unlicensed personnel and are within the legal scope of practice for unlicensed personnel.

M. Activities that may be delegated are determined by the following variables:

1. Knowledge and skills of the unlicensed personnel;

2. Verification of clinical competence of the unlicensed personnel;

3. Stability of the client's condition, which involves predictability, absence of risk of complication and rate of change, and thereby excludes delegation of nursing care activities which require nursing assessment or judgment by a licensed nurse during the performance of the activity.

4. The variables in each practice setting – which include but are not limited to:

    a. The complexity and frequency of nursing care needed by a given client;
    b. The proximity of clients to staff;
    c. The number and qualifications of staff;
    d. The accessible resources; and
    e. Established policies, procedures, practices and channels of communication that lend support to the types of nursing activities being delegated, or not delegated, to unlicensed personnel.

<u>Delegation/Assignment to other Unlicensed Personnel</u>

N. Delegation of nursing activities to other unlicensed personnel, such as Medical Office Assistants (MOA) and other technicians must be based on the same criteria used in delegating to Nurse Aides. That information is repeated below for emphasis.

O. The repetitive performance of a common task or procedure which does not require the professional judgment of a registered nurse or licensed practical nurse shall not be considered the practice of nursing for which a license is required. Tasks may be delegated to an unlicensed person which:

1. Frequently recur in the daily care of a client or group of clients;
2. Are performed according to an established sequence of steps;
3. Involve little or no modification from one client-care situation to another;
4. May be performed with a predictable outcome; and
5. Do not inherently involve ongoing assessment, interpretation, or decision-making which cannot be logically separated from the procedure(s) itself.

References: North Carolina Nurse Practice Act
NCAC 36.0221
21 NCAC 36.0024

21 NCAC 36 .0221 LICENSE REQUIRED

(a) No cap, pin, uniform, insignia, or title shall be used to represent to the public that an unlicensed person is a registered nurse or a licensed practical nurse as defined in G.S. 90-171.43.

(b) The repetitive performance of a common task or procedure that does not require the professional judgment of a registered nurse or licensed practical nurse shall not be considered the practice of nursing for which a license is required. Tasks that may be delegated to a Nurse Aide I and a Nurse Aide II shall be established by the Board pursuant to 21 NCAC 36 .0403. Tasks may be delegated to an unlicensed person that:

(1) frequently recur in the daily care of a client or group of clients;
(2) are performed according to an established sequence of steps;
(3) involve little or no modification from one client-care situation to another;
(4) may be performed with a predictable outcome; and
(5) do not inherently involve ongoing assessment, interpretation, or decision-making that cannot be logically separated from the tasks themselves.

Client-care services that do not meet all of these criteria shall be performed by a licensed nurse.

(c) A registered nurse or licensed practical nurse shall not delegate the professional judgment required to implement a treatment or pharmaceutical regimen that is likely to produce side effects, toxic effects, allergic reactions, or other unusual effects or that may rapidly endanger a client's life or well-being and that is prescribed by an individual authorized by State law to prescribe such a regimen. A nurse who assumes responsibility directly or through delegation for implementing a treatment or pharmaceutical regimen shall be accountable for:

(1) recognizing side effects;
(2) recognizing toxic effects;
(3) recognizing allergic reactions;
(4) recognizing immediate desired effects;
(5) recognizing unusual and unexpected effects;
(6) recognizing changes in a client's condition that contraindicates continued administration of the pharmaceutical or treatment regimen;
(7) anticipating those effects that may rapidly endanger a client's life or well-being; and
(8) making judgments and decisions concerning actions to take in the event such effects occur.

(d) If health care needs of a client are incidental to the personal care needs of the client, a nurse shall not be accountable for care performed by clients themselves, their families or significant others, or by caretakers who provide personal care to the individual.

(e) Pharmacists may administer drugs in accordance with 21 NCAC 46 .2507.

History Note: *Authority G.S. 90-85.3; 90-171.23(b); 90-171.43; 90-171.83;*
Eff. May 1, 1982;
Amended Eff. July 1, 2004; April 1, 2002; December 1, 2000; July 1, 2000; January 1, 1996; February 1, 1994; April 1, 1989; January 1, 1984;
Emergency Amendment Eff. September 10, 2004;
Amended Eff. April 1, 2008; December 1, 2004;
Readopted Eff. January 1, 2019.

(3) modifying the plan of care based upon newly collected data, new problem identification, a change in the client's status, and expected outcomes.

(f) Reporting and Recording by the registered nurse shall be those communications required in relation to all aspects of nursing care.

(1) Reporting means the communication of information to other individuals responsible for, or involved in, the care of the client. The registered nurse shall:
  (A) direct the communication to the appropriate individuals;
  (B) assure that these communications are consistent with established policies, procedures, practices, and channels of communication which lend support to types of nursing services offered;
  (C) communicate within a time period that is consistent with the client's need for care;
  (D) evaluate the responses to information reported; and
  (E) determine whether further communication is indicated.

(2) Recording means the documentation of information on the appropriate client record, nursing care plan or other documents. This documentation shall:
  (A) be pertinent to the client's health care;
  (B) accurately describe all aspects of nursing care, including assessment, planning, implementation, and evaluation;
  (C) be completed within a time period consistent with the client's need for care;
  (D) reflect the communication of information to other individuals; and
  (E) verify the proper administration and disposal of controlled substances.

(g) Collaborating involves communicating and working cooperatively with individuals whose services may have a direct or indirect effect upon the client's health care and shall include:

(1) initiating, coordinating, planning, and implementing nursing or multidisciplinary approaches for the client's care;
(2) participating in decision-making and in cooperative goal-directed efforts;
(3) seeking and utilizing appropriate resources in the referral process; and
(4) safeguarding confidentiality.

(h) Teaching and counseling clients shall be the responsibility of the registered nurse, consistent with 90-171.20(7)g.

(1) Teaching and counseling shall consist of providing accurate and consistent information, demonstrations, and guidance to clients, their families, or significant others for the purpose of:
  (A) increasing knowledge regarding the client's health status and health care;
  (B) assisting the client to reach an optimum level of health functioning and participation in self-care; and
  (C) promoting the client's ability to make informed decisions.

(2) Teaching and counseling shall include:
  (A) assessing the client's needs, abilities, and knowledge level;
  (B) adapting teaching content and methods to the identified needs, abilities of the clients, and knowledge level;
  (C) evaluating effectiveness of teaching and counseling; and
  (D) making referrals to appropriate resources.

(i) Managing the delivery of nursing care through the on-going supervision, teaching, and evaluation of nursing personnel shall be the responsibility of the registered nurse, as specified in the legal definition of the practice of nursing, and includes:

(1) continuous availability for direct participation in nursing care, onsite when necessary, as indicated by client's status and by the variables cited in Paragraph (a) of this Rule;
(2) assessing capabilities of personnel in relation to client status and the plan of nursing care;
(3) delegating responsibility or assigning nursing care functions to personnel qualified to assume such responsibility and to perform such functions;
(4) accountability for nursing care given by all personnel to whom that care is assigned and delegated; and
(5) direct observation of clients and evaluation of nursing care given.

(j) Administering nursing services is the responsibility of the registered nurse, as specified in the legal definition of the practice of nursing in G.S. 90-171.20(7)i, and includes:

(1) identification, development, and updating of standards, policies, and procedures related to the delivery of nursing care;
(2) implementation of the identified standards, policies, and procedures to promote safe and effective nursing care for clients;
(3) planning for and evaluation of the nursing care delivery system; and
(4) management of licensed and unlicensed personnel who provide nursing care consistent with Paragraphs (a) and (i) of this Rule including:
    (A) appropriate allocation of human resources to promote safe and effective nursing care;
    (B) defined levels of accountability and responsibility within the nursing organization;
    (C) a mechanism to validate qualifications, knowledge, and skills of nursing personnel;
    (D) provision of educational opportunities related to expected nursing performance; and
    (E) implementation of a system for periodic performance evaluation.

(k) Accepting responsibility for self for individual nursing actions, competence, and behavior shall be the responsibility of the registered nurse, including:
(1) having knowledge and understanding of the statutes and rules governing nursing;
(2) functioning within the legal boundaries of registered nurse practice; and
(3) respecting client rights and property and the rights and property of others.

History Note: *Authority G.S. 90-171.20(7); 90-171.23(b); 90-171.43(4);*
Eff. January 1, 1991;
Temporary Amendment Eff. October 24, 2001;
Amended Eff. August 1, 2002;
Readopted Eff. January 1, 2019.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: **MAINTENANCE OF LICENSURE, CERTIFICATION AND/OR CREDENTIALING RECORDS OF PROFESSIONAL STAFF**

DATE DEVELOPED: **5/00**
REVIEWED: **6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/24**

I. POLICY:

The Division of Public Health Services maintains current licensure, certification, and/or credentialing records for professional health care staff members and contract personnel required to have the same in order to provide health care services.

II. PURPOSE:

To ensure that professional health care staff members and contract personnel function with current, valid licensure, certification, and/or credentials.

III. GUIDELINES:

A. Copy of current, valid licensure certification, and/or credentials is submitted by newly hired professional health care staff members and contract personnel to the Director of Nursing/Staff Development Coordinator and Personnel Technician.

B. Verification of current, valid licensure, certification, and/or credentials for health care staff members and contract personnel is obtained by the Director of Nursing, Supervisor, or Staff Development Coordinator. **Per CCPN requirements, every employee that provides services on behalf of CCPN are screen against the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and General Service Administration System (GSA) exclusion lists prior to hire and monthly thereafter. The following websites are utilized (LEIE): https://exclusions.oig.hhs.gov/ and GSA: https://sam.gov/content/exclusions.**

C. A copy of current, valid licensure, certification, and/or credentials is submitted by hired professional health staff members and contract personnel at the time of renewal or as requested.

D. Any licensed or certified health care provider not submitting proof of licensure or certification renewal will be subject to disciplinary procedures appropriate until proof of renewal is submitted.

E. A completed summary of licensure certification and/or credentials is filed in the Personnel File and with the Staff Development Coordinator.

F. The Director of Nursing, the supervisors, or designee may verify current licensure certification for the nurses. The North Carolina Board of Nursing is called for Licensure Verification or the NCBON Website is viewed and a copy of licensure is printed. The Director of Nursing and the supervisors maintain a current listing of the certification dates of each professional staff members provided by the Staff Development Coordinator.

G. Licensure revocation notifications for RNs, LPNs, or NPs may be acquired through the North Carolina Board of Nursing via telephone or website. Licensure revocations for PAs or physicians may be acquired through the NC Medical Board via website.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: INITIALS AND SIGNATURES OF STAFF THAT PROVIDE CLIENT CARE

DATE DEVELOPED: 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16

I. POLICY:

All Division of Public Health Services' staff that provide direct client care will sign the charts using their first initial, last name, or first name and last name followed by their title (paper charts only). All charts are electronically signed in the electronic health record (EHR).

The signature and initials will be kept on file in the event of needed verification of actual signatures.

II. PURPOSE:

A. To provide a listing of employees that provide direct client care and in which they will be documenting on the client record.

B. To provide a system in which to verify the signature of an employee.

III. GUIDELINES:

A. Each client care staff member will submit their full name, as typed, written name and initials.

B. This listing will remain updated as name changes are made.

C. Each employee will need to update the listing as changes occur.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMPETENCY VERIFICATION

DATE DEVELOPED: 8/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

All health care staff will demonstrate competency in the range of skills necessary to perform their job responsibilities. Each program will have a measurable, assessment system to evaluate current competence. All positions will have a signed job description defining qualifications, knowledge, and skills needed for the job.

II. PURPOSE:

To assure the initial and ongoing competence of employees in order to protect the health, safety, and wellbeing of our customers.

III. GUIDELINES:

A. All newly hired client care staff and contract personnel will be closely monitored during their first 2-4 weeks of employment to ensure that each individual is competent in all skills required to fulfill the job position within the agency.

1. The appropriate supervisor or preceptor will observe each individual providing care to a client during at least two client contacts within the first month of employment.

2. All new client care staff will satisfactorily demonstrate all critical skills in the clinic (or home setting as indicated) prior to being assigned independently to clients requiring these skills.

B. The supervisors will monitor employee files periodically to ensure that critical competencies have been verified on an annual basis.

1. Competency may be observed and verified as part of routine supervisory visits or as part of an annual performance appraisal.

2. The competence of staff is maintained and improved through a combination of ongoing assessment and planned educational activities.

3. The Division of Public Health Services utilizes a variety of resources to assess, maintain and improve the competence of all staff members.

4. The Division of Public Health Services has adopted the Standards of Competency endorsed by The American Nurses Association.

C. Appropriate staff will be responsible for actual verification of competencies.

The Director of Nursing/Supervisors is responsible for ensuring annual competency evaluation of all licensed nursing staff is completed and documented in the personnel files.

D. Observation and/or training is performed by a clinical supervisor or preceptor - a qualified individual - in the area where the employee has rated himself or herself as having no or little knowledge and experience, or at the employee's request. On the job training is acceptable.

E. The organization assesses staff competence when new procedures or techniques are introduced and when changes in new or advance technology or equipment are made.

F. Information gathered from the staff competency testing may indicate training needs. Any patterns, trends identified are used to schedule in-service training for the staff.

G. At least once per year, each staff member providing direct care may be observed correctly performing the following critical competencies (high risk, high volume, problem prone activities). The Director of Nursing and/or Supervisors assesses nursing competencies.

1. Nursing - Full Time

- CPR (annually or every two years) - nursing staff, MOA, Advanced Practice Provider (APP), etc. all who deliver direct client care are expected to retain a current CPR registration. If for any reason anyone of the nursing staff is unable to attend a scheduled class, he/she must be excused by his/or direct supervisor or have a medical excuse. Direct client involvement may not be permitted until recertification of CPR is established. Additional staff may request to be certified in CPR, but are not required by the agency. Accommodations may be made to provide CPR training.
- Physical assessment/review of systems

The above will be performed as appropriate within the program.

2. The Medical Office Assistant - the Director of Nursing or Supervisor will assess the MOA competencies.

   - Ht., Wt., B/P, temp., pulse, resp.
   - Visual and/or hearing screens - if applicable to program

3. Medical Social Work – The Family Care Coordination Social Worker Supervisor will supervise the Social Work competencies as outlined in the Pregnancy Care Management and Care Coordination for Children programs.

   - Ability to display knowledge about community resources
   - Counseling skills
   - Problem resolution skills
   - Psychosocial assessment
   - Client/family teaching

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT REFERRALS

DATE DEVELOPED: 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/19

I. POLICY:

Referrals are accepted and made for services by qualified health care personnel. Admission of clients to the Division of Public Health Services based on a reasonable expectation that the client's therapeutic needs can be adequately met by the agency's staff members. Referrals are made to other agencies at the disclosure of the provider/nurse when care exceeds scope of practice or when certain tests/procedures are not available within the Division.

II. PURPOSE:

A. To ensure timely follow-up on all clients referred to the Division for services and for referrals that are made to outside agencies.

B. To establish specific admission criteria for acceptance of clients who request and/or are referred to this agency for health care services.

C. To access client referrals for appropriateness of care at the Division of Public Health Services.

1. Services offered

The Division of Public Health Services provides directly or by arrangement with another agency or individual for:

a. Clinical Nursing Services
b. Advanced Practice Provider (APP)
c. Nutritional services
d. WIC services
e. Social Worker
f. Lab services
g. Pharmacy services
h. Dental Services
i. Obstetric Case Management **(**Pregnancy Care Management)
j. Child Coordination for Children (CC4)
k. Newborn Home Visiting
l. Postpartum Home Visiting

m. Communicable Disease Coordination
n. Child Health
o. Pediatric Primary Care
p. Adult Health Primary Care
q. Chronic Disease Monitoring
r. Family Planning
s. Health Education

2. Availability of service

a. Acceptance of referrals:
1) Referrals are accepted Monday - Friday, 8:00 am - 5:00 pm. After hours and weekend referrals may be accepted by the Carolina Access on-call nursing staff. Referrals may be received by Registered Nurses/APPs. Orders may be received by nurses/APPs.
2) Services are offered to all in need of health care who meet the service criteria. No person will be denied services on the basis of age, race, color, creed, religion, political affiliation, national origin, or physical handicap.
3) Program referrals are received from the physician or his designee, community resources, hospitals, walk in client request, or through interagency programs.
4) Referral information can be accepted via any means of communication such as facsimile, telephone or direct contact with any member of the health care staff.
5) Program areas/Health Education may provide planned talks, health fairs, and information packets regarding services offered. Health Fairs and community involvement provides an opportunity for client recruitment.
6) Community outreach enables us to recruit clients for services through news releases, radio announcements, pamphlet distribution, directory of services brochures, etc., and/or through the health department web site www.rockinghamcountypublichealth.org or www.facebook.com.

b. Referrals may be received from the following but not limited to:
1) Interagency programs
2) Daymark Recovery (Mental Health provider)

3) The Division of Social Services
4) Private Physicians
5) Hospitals
6) NCCARE360

c. Referrals may be made for services not offered at the Division of Public Health Services:
1) Imaging testing
2) Lab tests
3) Pain management
4) Advanced disease care
5) Specialty services

d. Referral process to outside providers:
1) Medicaid
i. APP makes referral
ii. Appointment made by nurse or by referring office
iii. Client is notified of appointment time/location
2) Private Insurance
i. Client notified of referral by provider
ii. Client is responsible for making appointment if insurance does not require authorization
iii. If prior authorization is required, nurse will send agency the requested information.
3) NCCARE360 Electronic Portal

e. Time per visit:
1) The time spent with the client depends on the health care needs of the client and the time required to give adequate care.
2) Requests from clients for more than one service per day are evaluated and may be worked into the program schedule or scheduled for another appointment time, prioritizing the needs.

f. Geographical area covered:
Persons residing within the boundaries of Rockingham County who require health care services meet the service requirements. There are no residential requirements for services provided in the Family Planning Clinic and Immunization Clinic.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT CARE

DATE DEVELOPED: 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/19; 6/23

I. POLICY:

All services provided to the client will be in accordance with agency policies and a plan of care established in collaboration with the client.

II. PURPOSE:

A. To ensure consistent policies are followed relating to client care.

B. To establish consistent policies for employees.

III. GUIDELINES:

A. The employee will provide services to all clients of the health department upon request through proper channels. The agency alone has the responsibility for accepting clients for care. Referrals for all programs may be acquired through physicians, other community resources, hospitals, interagency referrals through the various programs, NCCARE360 portals, or walk in assistance through the health department clinic.

B. Services provided are to be within the scope set forth in the client plan of care and may not be altered except in case of an adverse reaction. The employee is responsible for coordinating service with the proper agency personnel on a continuing basis. Any alterations in the plan of care require proper communications and coordination with other agency personnel involved in the care of the client. Any such modification of the plan will be noted in the medical record.

C. The employee shall become familiar with the agency's objectives and procedures and will abide by the agency policies pertaining to services and client care.

D. The employee shall maintain records on forms provided by the agency and submit these to the client record on a timely basis according to policy. All forms used within the agency for client care must be approved for use through the agency's record committee. Each program approved form will be assigned a form number if it becomes a part of the permanent record.

E. The Division of Public Health Services shall make available all records and information relevant to the client for purpose of services being provided. All information is documented in the electronic health record (EHR). All EHR charts are signed and locked within two business days of the date of service. The employee must maintain records and reports in accordance with the policies of the agency. The Advanced Practice Provider's (APP's) charts are reviewed by the supervising physician at either party's request.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMMUNITY OUTREACH

DATE DEVELOPED: 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/23

I. POLICY:

The Division of Public Health Services strives to ensure health promotion and wellbeing and disease prevention. This goal is often accomplished through various community events, industrial and community health fairs.

II. PURPOSE:

A. To inform the citizens of Rockingham County of the various services available at the Division of Public Health Services and other human service agencies.

B. To identify at risk individuals in need of health care.

C. To act as a liaison for the client between employment services and health care issues.

D. To assist with implementation of health care services as needs are identified.

E. To increase the use of public health programs and services.

III. GUIDELINES:

A. The Division of Public Health Services encourages community involvement in establishing services and target populations in need of health care.

This is accomplished by various community resource input in developing the Rockingham County State of the County Health Report.

1. The Rockingham County School Systems are involved in developing criteria essentially aimed at that population of needs.

2. Health Promotion topics are developed in collaboration with other community resources.

B. The Division of Public Health Services provides media news releases, advertisements, and health updates in the county newspapers, Rockingham County Department of Public Health website @ www.rockinghamcountypublichealth.org or www.facebook.com and through radio announcements. Announcements of vaccination clinics are made through newspapers, radio, television, faith based groups, mailings to private providers, hospitals, etc. within the community.

Notices may be emailed to physicians, hospitals, pharmacies, dentists, and/or possibly veterinarians.

Pamphlets and Directory of Services about health department services may also be distributed in the following locations but are not limited to:

1) Churches
2) Organizations/clubs
3) Senior Centers/Nutrition Sites
4) Rockingham County Council on Aging
5) Daymark Recovery Services
6) Rocking County Schools/Student Health Centers
7) Rockingham County Department of Social Services
8) Rockingham County Hospice
9) Advanced Homecare
10) Child Care Facilities
11) Parks and Recreation Agencies

Information distributed may be presented in Spanish and in English.

C. Surveillance measures are implemented through at risk areas to promote prevention of communicable diseases.

D. Physicians and other community resources are kept updated on changes in specific procedures or trends that require notification of illnesses to the local health department.

E. The Division of Public Health Services may provide staffing during outbreaks through clinic sites made available at the various locations throughout the county to meet the needs of any private organization, group, church or total population's needs in order to provide vaccinations aimed specifically at the target population.

F. All State contract addendum outreach requirements are followed.

G. Pamphlets, brochures, and program specific information/agency directory of services are routinely distributed throughout the health department and community, and are available upon request.

H. The Division of Public Health Services introduces new employees to the program areas to better acquaint them with the various programs available. This is established in order to facilitate a better continuity of client care in making inter-agency referrals as the needs are identified. Updates are made available as indicated.

I. Intra-agency collaboration and referral is encouraged throughout the Division of Public Health Services. Referrals may be made among programs as indicated.

J. The Division of Public Health Services collaborates its efforts with all of the Rockingham County resources available.

1. The Division of Public Health Services provides community outreach and education to clients and general population on health department and other human services available in the county as needed.

2. Rockingham County Employees make referrals to other agency services as required/eligible by the client. This may include but is not limited to:

    a. Daymark
    b. Department of Social Services
    c. Integrated Care
    d. Hospice
    e. Private physicians for follow-up care not provided at the health department
    f. Hospitals for extended care

3. Rockingham County receives referrals for clients in need of health services.

K. All staff members of the Division of Public Health Services may assist with the community outreach projects. The Community Health Educator organizes most of the outreach programs.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MANDATORY REPORTING OF ABUSE/NEGLECT AND HUMAN TRAFFICKING

DATE DEVELOPED: 6/12/96
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/21; 6/22

I. POLICY:

To provide a safe environment for client care and report any cases of abuse as appropriate. The Division of Public Health Services Staff, who have knowledge of or suspect a child or disabled adult of being abused, neglected, or exploited, have the legal obligation to report the abuse or suspicion of abuse.

II. PURPOSE:

A. The Division of Public Health Services' Staff reports all suspected cases of abuse and/or neglect in compliance with North Carolina legislation and statute, G.S.14-318.6 and S.L.2019-245 (s199), NC State Law 108A-104 which states, any person having reasonable cause to believe a disabled adult or child needs protective services shall report to the Department of Social Services (DSS). If the offense that has been reported is serious bodily injury, serious physical injury, or a violent offense, law enforcement will be notified in conjunction with DSS.

B. To prevent or correct situations of actual or suspected abuse/neglect and human trafficking.

C. To recognize potentially abusive situations and to educate and improve quality of life in the home setting.

Definitions:

1. Abuse – Any act that constitutes a violation of the prostitution or criminal sexual conduct statutes, the intentional and nontherapeutic infliction of pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. The willful infliction of physical pain, injury, mental anguish, unreasonable confinement, or the willful deprivation of essential services.
2. Neglect – Failure of caregiver to supply vulnerable adult or child with necessary food, clothing, shelter, health care or supervision or absence or likelihood of absence of necessary food, clothing, shelter, health care or supervision of vulnerable adult or child.

3. Child – Any person under the age of 18.
4. Disabled Adult – A person 18 or older or any lawfully emancipated minor in the State of NC who is mentally or physically incapacitated.
5. Exploitation – The illegal or improper use of an individual or that individual's resources for the profit/advantage of another person.
6. Neglect – The absence or omission of essential services to the degree that it harms or threatens with harm the physical or emotional health of a child or disabled adult.
7. Sex Trafficking – The recruitment, harboring, transportation, providing or obtaining of a person for a commercial sex act, in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age.
8. Labor Trafficking – The recruitment, harboring, transportation, provision or obtaining of a person for labor or services, by force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

III. GUIDELINES:

A. Indicators of Adult Abuse

1. Physical Abuse – adult has been:

   a. Beaten
   b. Whipped
   c. Burned
   d. Chained
   e. Tied or restraint marks on wrists/ankles or holding a person against their will
   f. Locked in room, home
   g. Decubuti/urine burns
   h. History of unexplained injuries
   i. Repeated falls
   j. Burns in unusual places
   k. Bruises/fractures or multiple injuries in various stages of healing
   l. Sexually transmitted diseases
   m. Unexplained malnutrition and dehydration
   n. Hitting
   o. Shoving
   p. Choking
   q. Using a weapon
   r. Twisting an arm

2. Emotional Abuse:

   Can be difficult to recognize, but is just as serious as physical abuse. Emotional abuse may include:

   a. Making threats
   b. Humiliating a person through put-downs, name-calling, etc.
   c. Taking or destroying a person's property
   d. Forbidding a person to leave the house or see friends

3. Sexual Abuse:

   May involve people of any age. It may include:

   a. Rape (sex forced on a person, including sex forced on a partner)
   b. Pressuring a person to have sex
   c. Making comments or behaving in ways that make a person feel like a sexual object
   d. Human trafficking
      - Those 18 or over involved in commercial sex via force, fraud or coercion
      - Minors induced into commercial sex
      - Adults or minors in forced labor, services or involuntary servitude via force, fraud, or coercion

4. Behavioral Indicators:

   The adult may exhibit:

   a. Poor hygiene
   b. Extreme mood changes
   c. Listlessness, depressed
   e. Fearfulness
   e. Frequent change in healthcare provider
   f. Evidence of items missing (losing items/misplacing items)
   g. Reports of inability to get medicine or medical care
   h. Abandonment
   i. Suicide attempt or gesture
   j. Setting small fires

5. Stalking (A pattern of harassing someone)

   The person may have experienced:

   a. Someone following them in public – being followed
   b. Someone communicating telephone threats
   c. Being stalked

6. Labor Trafficking:

   a. Inability to keep appointments or follow care instructions
   b. Accompanied by a person that does not allow client to speak
   c. No identification documents
   d. Addictive behaviors
   e. Hyper-vigilance, fear, paranoia, anxiety, depression

B. Indicators of Adult Neglect

1. Self-Neglect

   a. Unable to communicate
   b. Unusual thinness
   c. Disregard for streetlights, traffic
   d. Forgetting to light or turn off gas
   e. Aimless wandering at night
   f. Having a series of accidents
   g. Inability to cook, eat, bathe, dress – care for one's person
   h. Lack of food or shelter
   i. Living facility dilapidated
   j. Bathroom not usable
   k. Water supply unsanitary or unavailable
   l. Rat, roach infested home
   m. Untrained dogs, cats
   n. Isolated rural area
   o. Incontinent
   p. Bed confined
   q. Self-mutilating
   r. Threatening suicide
   s. Threatening harm to others
   t. Unable/unwilling to get needed medical care; has obvious physical problems for which client receives no treatment; has pallor, paralysis, tremors, speech difficulty, excessive fatigue, weakness, falling, dizziness, persistent pain, loss of circulation in limb, inability to ambulate, other physical symptoms.
   u. Unable/unwilling to get needed mental health care; has frequent or prolonged periods of depression, crying, apathy, feelings of persecution, excessive nervousness, irritability, explosive anger, others.

C. Neglect by Caregiver

1. Lacks provision of adequate food, shelter, clothing, access to medical care, attention to personal and incidental needs.

2. Resources not being managed to meet needs.

3. Medical needs not being met or arranged for by caretaker.

4. Personal needs not being met by caretaker; i.e., food preparation, laundry, shopping, cleaning, etc.

5. Living situation hazardous to health and safety.

D. Indicators of Exploitation:

1. Sexual exploitation/Human trafficking

a. Under age 18 and in commercial sex
b. Language from "the life"
c. Persistent or untreated STIs or UTIs
d. Abnormally high number of sex partners
e. Trauma to vagina or rectum
f. Presence of cotton or debris in vagina
g. Repeated abortions or miscarriages
h. Unintended pregnancies or fertility problems
i. Hematoma or contusions
j. Lacerations or scarring
k. Missing or broken teeth
l. Dislocated limbs or fractures
m. Bald spots
n. Burns (e.g., cigarette burns)

2. Financial exploitation:

a. Transferring estate to another person

- Real Estate
- Stocks, bonds, etc.
- Bank account, etc.

b. Money is gone day after "check day"
c. Buys expensive gifts, gives away money to strangers
d. If in a rest home and a relative is payee – no spending money

E. Indicators of Potential Abusive Caregivers:

1. Poor preparation to provide care to client

2. Unrealistic expectations of client

3. Increased physical workload

4. Unrelieved responsibility for the client
5. Resentment toward the client
6. Financial Stress
7. Drug/alcohol abuse/dependency
8. Frustration
9. Low self-esteem
10. Ineffective communication skills
11. Sleeplessness
12. Marital difficulties
13. Interfamily conflict
14. Lack of external support systems
15. Social isolation

F. Child Abuse

1. Physical Indicators – Children under age 18:

   a. Bruises and welts in various stages of healing
   b. Fractures
   c. Internal injuries
   d. Punctures, abrasions, other wounds
   e. Head injuries
   f. Unexplained malnutrition or failure to thrive
   g. Burns
   h. Genital/anal injury or disease
   i. SIDS as cause of death

2. Reports of Neglect:

   In North Carolina, a neglected juvenile is one who:

   - does not receive proper care, supervision, or discipline from the parent, guardian, custodian, or caretaker;
   - has been abandoned;
   - has not been provided necessary medical care;
   - lives in an environment injurious to the juvenile's welfare; or
   - has been placed for adoption or care in violation of the law.

If the level of care provided to the child is harming the child's growth or development, and the parent, guardian, or caretaker has the means to provide for the child, it is considered to be neglectful. If the family does not have the money to provide adequate physical or medical care, the Division of Social Services can help them find resources to provide for their children.

Regardless of the family's circumstances, it is the health care worker's responsibility to report any suspected neglect to Child Protective Services in the local Division of Social Services. Some indicators of neglect are:

- Abandonment of a child by the parent, guardian, custodian or caretaker
- Unattended medical problems, including illness and physical conditions that can be treated or cured with appropriate therapy
- Consistent lack of supervision or inappropriate supervision by the parent, guardian, custodian or caretaker
- Ongoing drug or alcohol abuse by mother that results in positive drug screen on newborn or that interferes with her ability to provide supervision and care
- Consistent hunger, inappropriate clothing, or poor hygiene
- Distended stomach
- Indiscriminate affection
- Frequent absence from school or day care
- Child is extremely tired or sleepy
- Unexplained delays in intellectual, social or physical development
- Physical or social environment is dangerous to the child's safety

Reports of Dependency

A dependent child is a juvenile in need of assistance because the child either has no parent, guardian or custodian responsible for his care or supervision or because the parent, guardian or custodian is unable to provide for care or supervision because of some physical or mental incapacity and has not made arrangements for the child.

3. Behavioral Indications:

   a. No crying or excessive crying
   b. Behavioral extremes, aggressiveness, or withdrawal
   c. Unusually fearful, indiscriminate in affection to health

d. Developmental delay, emotional or physical handicap
e. Afraid to go home
f. Child reports injury by parents or other caregiver
g. Consistent hunger
h. Consistent lack of supervision
i. Suicide attempt or gesture
j. Inappropriate dress (for age, gender, weather, etc.)
k. Child tries to nurture parent
l. Abandonment by parent or caregiver

4. If a health care worker suspects abuse, neglect, or dependency of a child, the worker is required by law to report this to the Division of Social Services who may in turn report to law enforcement if the offense is deemed violent, sexual offense, or misdemeanor child abuse. When at all possible the worker is encouraged to talk first with the family about his/her concerns, explain his/her obligation to report and to place this in the context of both safety for the child and additional support for the family. In some cases the worker may ask the parent if he/she will make the call with the worker. Exceptions to talking with a family before reporting would be situations in which the health care worker has concerns about his/her personal safety or the safety of the child should the family refuse to cooperate with reporting.

   All suspected cases of child abuse are to be reported to the Division of Social Services by the Division of Public Health Services' staff.

   Division of Social Services – 336-342-1394
   Child Abuse/Neglect – 336-342-3537

   Child abuse or the battered child syndrome describes the non-accidental or deliberate physical attack on or injury of infants and children. Child neglect and deprivation is another form of child abuse.

5. It is recommended that the worker discuss the situation with his/her supervisor and that health department administration be informed that the report is being made.

6. <u>Recognition of the abused child:</u>

   a. Child having minor to soft tissue injuries, or fractures which were assumed to have resulted from accidents
   b. May show evidence of nutritional and/or hygienic neglect, such as anemia, skin rashes, and "failure to thrive".

7. Abused children respond in ways that are characteristic of abuse:

   a. Cries helplessly during treatment or examination without any real expectation of being comforted, or cries very little.
   b. Does not look to parent (if abuser) for assurance or may actively avoid parent.
   c. Is wary of physical contact initiated by abusive parent or others.
   d. Appears constantly on the alert for danger.

8. Characteristics of the abusive adult:

   a. Evidences immature behavior and is preoccupied with him or herself.
   b. Seldom touches or looks at the child or becomes involved in the care.
   c. Is unconcerned about the child's injury, treatment, or prognosis.
   d. Gives no indication of guilt or remorse that the child is injured; may blame the child for becoming injured.
   e. Is concerned more about what will happen to him or herself and others involved in the child's injury than about the welfare of the child.

9. Behavioral indicators of parent or caregiver:

   a. Gives vague or contradictory history that doesn't explain injury or history of repeated injuries
   b. Has delayed bringing child in for care
   c. Shows inappropriate awareness and understanding of the seriousness of child's injury or condition
   d. Evidence of loss of control or fear of losing control
   e. Seeks nurturance from child
   f. Is psychotic or psychopathic
   g. Refuses further diagnostic studies or hospitalization
   h. Frequently changes child's health care provider
   i. Projects blame for child's injury on sibling or other person
   j. There may be a situation that does not meet the criteria for abuse, neglect or dependency but yet may not be in the best interest of the child. In this situation, the preferred approach would be to maintain contact with the family, attempt to establish rapport, listen to their concerns and offer encouragement, education and possibly referral for other services.

10. Indicators by Domestic Partners:

    a. Inconsistent description of injury or incident
    b. History of repeated injuries
    c. Nervousness, fear in history giving, poor eye contact
    d. Denial of abuse, despite obvious signs
    d. Spouse/partner speaks on behalf of client when client can speak for self
    e. Client reluctant to speak in front of partner
    f. Injury during pregnancy or pre-term labor
    g. Chronic and vague medical complaints
    h. Bruises in various stages of healing
    i. Vaginal or anal trauma
    j. Depression, anxiety, suicide attempt or gesture
    k. Substance abuse

11. Indicators for Labor Trafficking:

    a. Dehydration, heat stress/stroke
    b. Sleep deprivation
    c. Musculoskeltal and ergonomic injuries
    d. Pesticide or chemical exposure
    e. Water and sanitation related illness
    f. Air quality or respiratory problems
    g. Untreated skin infections/irritations
    h. Evidence of sexual abuse
    i. Inability to keep appointments or follow care instructions
    j. Accompanied by a person that does not let client speak
    k. No identification documents
    l. Addictive behaviors
    m. Hyper-vigilance, fear, paranoia, anxiety, depression

G. Assessment

1. Examine closely for effects of under medication, overmedications, assess nutrition, hygiene, and personal care for evidence of abuse/ neglect (i.e., dehydration or malnourishment without illness-related cause).

2. Burns, unusual location, or type.

3. Physical or thermal injury on head, scalp or face.

4. Bruises and hematomas:

    a. Bilaterally on soft parts of body, not over bony prominences (knees and elbows), inner arm/thigh bruises are very suspicious.
    b. Clustered as from repeated striking.
    c. Shape similar to an object or thumb/finger prints.
    d. Presence of old and new bruises at the same time as from repeated injury, injuries in different stages of resolution.
    e. Presence of bruises after changing health care provider or after prolonged absence from health care agency.

5. Mental status and neurological exam changes from previous level.

6. Fractures, falls or evidence of physical restraint. Contractures may indicate confinement for long periods.

7. Ambulation status – poor ambulation may be suggestive of sexual assault or other "hidden" injuries.

H. Policy Reporting

1. Report facts/suspicions to immediate supervisor.

2. A verbal report will be made immediately to the client's attending physician and law enforcement which may in turn report to the Division of Social Services. The Adult greater than 18 years of age may be directly reported to the Division of Social Services only.

    a. Information to report:
        1) Name, address and age of client
        2) Name and address of caregiver or guardian
        3) Nature and extent of injuries/neglect
        4) Evidence of previous injuries/neglect
        5) Information pertinent to an understanding of the course of injuries/neglect

    b. If the Division of Social Services does not make follow-up call to the agency, immediate supervisor should call Department of Social Services for follow-up.

Note: Regarding immunity according to G.S. 108A-102: Anyone making a report pursuant to this statute who testifies in any judicial proceeding arising from the report or who participates in a required evaluation shall be immune from any civil or criminal liability on account of such report or testimony or participation, unless such person acted in bad faith or with a malicious purpose.

I. Protective Action

Social Services shall report simultaneously to Adult Protective Services and the appropriate law enforcement agency.

- If the client is mentally competent and consents to protective service for the adult
- If the caregiver of a disabled but mentally competent adult refuses the receipt of protective services to the disabled adult, then the district court may be petitioned for an order to prevent the caregiver from interfering with protective services.
- If the disabled but mentally competent adult refuses protective services, it shall not be provided. (Refer to NC State Law 108A-104).
- If a disabled, mentally incompetent adult is in need of protective service, the district court may be petitioned to authorize protective services (NC State Law 108A-105).
- For human sex trafficking
  a. Follow existing protocols for child abuse, child molestation, sexual abuse, rape, incest, and domestic violence
  b. Explain reporting obligations
  c. Provide options
  d. Consider the client's age, immigration status
  e. Provide the National Human Trafficking Resource Center (NHTRC) hotline number
  f. Report to HHS foreign national child victims
- Foreign National Minors
  - ❖ Federal, State, or local officials are required to notify HHS within 24 hours of discovering a child who may be a foreign victim of trafficking

J. Documentation

1. Any report of suspected abuse or neglect must be documented in the medical record.

2. Documentation should include:

   a. A statement that law enforcement or other relevant agency was notified
   b. Date of referral
   c. Brief objective description of the reason for referral and whether or not this was discussed with the family

d. If the documentation is made by a paraprofessional, it is strongly recommended that it be co-signed by a clinic supervisor.

3. The Victim Compensation Program is available to rape victims for up to one year after the crime, but only if the victim cooperates with the law enforcement agency. Number to call is 1 800-826-6200.

4. Daymark Recovery Services – 336-342-8316

5. Help, Inc. – 336-342-3331 – Adult Abuse Shelter

6. Child Abuse/Neglect – 336-342-3537 or 336-342-1394.

7. Adult Protective Services – 336-342-1394.

8 Rockingham County Social Services – 336-342-1394.

9. National Human Trafficking Resource Center (NHTRC) 24/7 TOLL-FREE National Hotline – 1-888-373-7888.

IV. DEPARTMENT OF SOCIAL SERVICES:

A. In North Carolina, each county department of social services has the legal responsibility and authority to investigate reports suspected child abuse, neglect, and dependency.

B. After you have made a child protective services report to the county department of social services who in turn may contact law enforcement. Law enforcement will decide whether or not to investigate. This decision is reviewed by a supervisor (DSS) to make sure that no child goes unprotected if the report meets the legal definition of abuse, neglect, or dependency. You will be told if the agency does not investigate, along with the reasons why not. You can ask for a review if you disagree with that decision

C. All employees will be aware of and abide by the NC state statute regarding child abuse and neglect reporting laws.

UNC School of Government: bbs.unc.edu

V. REFERENCES:

G.S.14-318.6 and S.L.2019-245 (s199)

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMERGENCY CARE

DATE DEVELOPED: 5/11/94
REVIEWED: 2/16; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 2/16; 6/17; 6/18; 6/22; 6/24

I. POLICY:

The Division of Public Health Services' members will implement emergency action for clients in a crisis situation, as appropriate.

II. PURPOSE:

To intervene appropriately in an emergency situation.

III. GUIDELINES:

A. A medical emergency includes any sudden change in the client's condition or the onset of symptoms which requires immediate response to reverse.

B. In the event of an emergency, the Division of Public Health Services' staff may take nine action steps:

1. The switchboard operator or designee may identify the emergency situation as such by notifying staff via the intercom system or via telephone.

2. Remove the client from danger, if applicable.

3. Restore and/or maintain the client's breathing and heartbeat using CPR, if necessary, or by implementing use of the Automatic External Defibrillator.

4. Control any heavy bleeding of the client by applying direct pressure to the site.

5. Treat any poisoning of the client.

6. Prevent shock by keeping the client lying in a comfortable position, warm and dry.

7. Examine the client carefully for obvious injuries.

8. Seek emergency help for the client by dialing the 911 emergency telephone number.

9. Continue to monitor the client until medical help arrives.

C. When an emergency occurs, the staff nurse, MOA, or Advanced Practice Provider (APP) will remain with the client until medical supervision can be obtained.

D. The supervisor or designee will also respond to the emergency location. At the time of the emergency – procedures are delegated among responders.

E. Staff must document all actions, interventions, and outcomes in the medical record as soon as possible following the emergency event. For people who are <u>not</u> clients of the Division of Public Health Services, documentation will be kept secured in the Clinical Nurse Supervisor's file cabinet.

F. In the absence of physician instructions to the contrary, medical emergencies might include:

1. Significant changes in vital signs

2. Abnormal bleeding

3. Difficulty in breathing with:

   a. Cyanosis
   b. Change in state of consciousness
   c. Severe wheezing

4. Cardiopulmonary arrest

   a. If the client has a cardiac or respiratory arrest and there is not a "No Code Order" or "Do Not Resuscitate" order in the medical record, CPR should begin immediately and 911 called immediately for assistance and client physician notified.
   b. The client should be sent to the nearest emergency room.

5. Anaphylaxis – may occur during or after administration of medications, insect bites or other known allergens.

   <u>Early Symptoms to be Observed Are</u>:

   a. Feeling of uneasiness or apprehension, weakness, perspiration, sneezing or nasal pruritus.
   b. Generalized pruritus and urticaria. These mild reactions are rapidly followed, sometimes in a matter of seconds or minutes, by the following:

      (i) Edema of face, hands and other parts of the body

(ii) Wheezing respirations, dyspnea, cynosis and dilation of the pupils

6. Profuse/prolonged vomiting, diarrhea

7. New paralysis

G. If a client or caregiver calls the health department describing one of these medical emergencies, the caller should be instructed to call 911 for immediate medical assistance.

H. If one of these medical emergencies arises while an employee is with the client, the following steps will be taken, in the absence of instructions to the contrary from the patient (verbally or in a valid advance directive) according to employee skill level:

1. Evaluate the client's condition

2. Call the emergency medical response unit (911)

3. In the event of cardiopulmonary arrest, initiate appropriate lifesaving procedures

4. EMS will notify the client's physician or emergency room

5. Notify the client's emergency contact

6. Document circumstances, actions taken and time frames in the medical record

7. Notify the supervisor as soon as possible

I. Emergency Care Guidelines include, but are not limited to the following:

1. Anaphylaxis (from medication, insect bites or allergens)

a. Discontinue medication or remove allergen.
b. Call client's physician or emergency room.
c. If respiratory difficult, call Emergency Medical Response unit (911).
d. Start CPR if necessary, unless client has an advance directive otherwise.
e. Contact pharmacist where prescription for medication causing reaction was prepared to inform of the untoward reaction by the patient (if severe drug reaction occurs).
f. Follow the standing orders for severe drug reactions found on the Emergency Bag.

The Automatic External Defibrillator (AED) is kept on the shelf in Room 11. Quality measures are assessed according to the AED policy.

(1) Emergency Bag drugs are labeled on the exterior as to:

(a) Contents
(b) Expiration date of the first expiring item

(2) If the reaction is severe and delay is not feasible, systemic allergic symptoms should be treated promptly with subcutaneous injection of 0.1 to 0.5 ml 1:1000 Adrenalin (Epinephrine). The Adrenalin dose can be repeated per standing orders if physician cannot be reached.

(3) The client should rest quietly and be observed as long as symptoms persist). Administer oxygen if warranted.

(4) Symptoms to observe for are edema and itching at the injection site. These mild reactions are rapidly followed, sometimes in a matter of seconds or minutes, by edema of face, hands and other parts of the body. Wheezing respirations, cyanosis, dyspnea, dilation of the pupils, rapid weak pulse and falling blood pressure.

(5) Transfer client to the hospital as soon as possible. Call Emergency Medical Services – 911. Remain with client until EMS arrives.

(6) Safety Factors:

(a) Adrenalin dose may be repeated at 20 minute intervals.
(b) Monitor vital signs especially blood pressure. Assess for hypotension and respiratory distress.

(7) Dose of Adrenalin 1:1000 0.01 ml per kilogram or .005 ml per pound of body weight.

To be used in emergency if no time for calculation:

WEIGHT	DOSAGE
10 lbs	0.05 ml
20 lbs	0.10 ml
30 lbs	0.15 ml
40 lbs	0.20 ml
50 lbs	0.25 ml
60 lbs	0.30 ml

70 lbs	0.35 ml
80 lbs	0.40 ml
90 lbs	0.45 ml
100 lbs	0.50 ml

NO MORE THAN 0.50 ML

(8) If available, an EpiPen or EpiPen Jr may be administered using the following guidelines:

Weight	Dosage	Device	Repeat x 1	Site	Route
33-66 lbs.	0.15 mg	EpiPen Jr	10-15 minutes	Anterolateral thigh	IM
Over 66 lbs.	0.3 mg	EpiPen	10-15 mintues	Anterolateral thigh	IM

(9) Repeat adrenalin, if necessary, or per table if using EpiPen or EpiPen Jr.

2. Suspected Drug Overdose

   a. Try to identify the medication.
   b. Call Emergency Medical Response (911) and the client's physician.
   c. Administer Narcan per package instructions and APP direction. Document and report to emergency personnel.
   d. Begin CPR if necessary, unless client has an advance directive to contrary.

3. Sudden, Severe Abdominal Pain

   a. No fluids, food or medication by mouth
   b. Contact physician as soon as possible with symptoms.
   c. Seek further emergency care.

4. Thermal Burns

   a. Do not apply ointments, cotton or break blisters.
   b. If skin is reddened and no blisters, hold under cold running water.
   c. If blistered, cover with loose clean cotton cloth and seek medical care immediately.

5. Chemical Burns

   a. Wash off the area with large amounts of cool water.

b. Seek medical care immediately – may need Emergency Medical Response Team (911).
d. Contact client's physician.

6. Convulsions (with/without past history)

a. Lay client flat, in recovery position, and turn head to side.
b. Don't restrain any more than necessary to prevent client from hurting self.
c. Do not place anything between client's teeth.
d. Keep client quiet and allow to rest after convulsion.
e. Seek medical attention as condition warrants.
f. Notify client's physician of event.

7. Fainting

a. Place client in a supine position (prevent aspiration as indicated).
b. As client condition dictates, seek medical care as soon as possible.
c. Do not permit client to sit or stand up immediately.
d. Keep client warm.

8. Suspected Fracture

a. Make client as comfortable as possible without lifting or moving.
b. Support suspected site of fracture with a pillow or rolled blanket.
c. Call Emergency Medical Services (911) and notify client's physician.

9. Hemorrhage

a. Apply direct pressure to the bleeding site.
b. Elevate the bleeding site if possible.
c. Call Emergency medical Services (911) and notify client's physician.
d. Report exposure of blood to Agency Supervisor and follow post exposure procedures.

10. Suspected or Known Poisoning

a. Call Emergency Medical Services (911) immediately and client's physician.
b. Locate poison container and send with client.
c. Save any vomitus for examination by physician.
d. Contact Poison Control Center as indicated.

11. Animal Bite

    a. Move client to safety.
    b. Notify Animal Control Center.
    c. Wash wound with soap and running water for five minutes.
    d. Cover bite with dry, clean cloth.
    e. Send client for medical treatment as soon as possible.
    f. Send identifying information with client to physician or emergency room.

12. The Division of Public Health Services is not an emergency facility. However, clinical staff are trained in how to initiate emergency care until EMS arrives. The following emergency procedures may be followed as an emergency occurs:

    a. The Emergency Bag is prepared and maintained by nursing/ pharmacy staff – checked 1 x per month. The Emergency Bag is located in Room 11.
    b. An emergency kit is available on the emergency bag and contains:

        - Adrenalin (Epinephrine) 1mg 1:1000 **and/or Epi Pen**
        - Syringes 3cc
        - Alcohol swabs
        - Adrenalin dosage chart
        - Needles 25g 5/8”
        - Filter needles 19g 1-1/2”
        - Ventilation mask

        Additional items may include:

        - Portable O2 unit
        - Nasal cannula
        - Ambu bag
        - Sphygmomanometer with varying cuff sizes
        - Stethoscope

    c. The following items are located in the bag and require a one-time or stat order from the medical doctor or provider. Emergency drugs include the following:

        - Benadryl 25 mg capsules
        - Aspirin 81mg chewable tablets
        - Glucose

    d. A small emergency kit is located in the Family Planning Workroom – 28B. This kit is prepared and maintained

by the nursing/pharmacy staff and is checked one time per month. The kit is housed in the medical filing cabinet and contains the following:

- Adrenalin (Epinephrine) 1 mg 1:1000 **and/or Epi Pen**
- Syringes 3cc
- Alcohol Swabs
- Adrenalin dosage chart
- Needles 25g 5/8”
- Filter needles 19g 1-1/2”
- Ventilation mask

13. Additional Emergency Kits are stored in each clinical room. Those contain the following:

    a. Face mask
    b. Goggles/face shield
    c. Spill kits

J. Resuscitation/Do not resuscitate

1. The Division of Public Health Services’ staff involved in client care such as nurses, APPs, and medical office assistants are to initiate CPR in the event of any cardiac or respiratory arrest unless there is a duly executed advance directive or physician order to the contrary.

2. When a DNR order is deemed appropriate by the nurse or APP this will be discussed with the client/family.

K. Training to Staff:

1. The Emergency Care Policy is reviewed with the staff during their orientation phase, annually, and as necessary.

2. Clinical Staff are required to train in CPR and remain current.

3. Additional staff may request to be trained in CPR however they are not required by the agency.

4. Staff are trained during orientation and annually of fire safety, fire plan, exit routes, location of fire alarms and fire extinguishers.

5. Staff are trained during orientation and annually on general work place safety and personal safety.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CODING OF SERVICES

DATE DEVELOPED: 7/05
REVIEWED: 6/17; 6/18; 9/18; 6/19; 6/20; 6/21; 6/22; 9/22; 6/23; 6/24
REVISED: 6/17; 9/18; 6/22; 9/22

I. POLICY:

The Division of Public Health Services uses CPT, ICD and Dental Coding when providing health care services.

II. PURPOSE:

CPT/ICD and/or Dental Codes are used to show the service and diagnosis provided and/or assigned to the client.

III. GUIDELINES:

CPT Codes and ICD

1. Principles of CPT Coding are based on Medical Decision Making which includes:

    a. The number and complexity of problem(s)
    b. The amount and/or complexity of data reviewed and analyzed
    c. The risk of complications, morbidity, and/or mortality of patient management decisions.

2. Principles of CPT Coding for time on date of the encounter:

    a. Includes both face-to-face (required) and non-face-to-face time
    b. Counseling or coordination of care dominates the care

3. Documentation for each client encountered should include:

    a. reason for encounter and relevant history, physical examination findings, and prior diagnostic test results
    b. assessment, clinical impression or diagnosis
    c. plan for care
    d. date and identity of the observer or by audit trail
    e. rationale for ordering lab or diagnostic tests and tests must correlate to diagnosis
    f. codes used should be supported by the documentation in the clinical record.

4. The Advanced Practice Provider (APP) should document the following to support treatment and coding.

    a. Chief Complaint for each visit.
    b. History –
        1) Present History should detail the Chief Complaint, present illness, review of systems, past family and social history.
        2) History of present illness and pain level should list the following elements.

            Location – where the problem is
            Quality – dull or sharp
            Severity – on a scale of 1–10
            Duration – how long does it last
            Timing – when does it happen
            Context – does anything trigger it
            Modifying factors – does anything make it better or worse
            Signs and Symptoms

    c. Review of symptoms: inventory of body systems seeking to identify signs and/or symptoms and document client's response.
    d. Past family, and/or Social History (PFSH):

        - Document whether updated changes/no changes.
        - Past History – review of client's past experience with illnesses, operations, injuries and treatments, current medications, allergies, age appropriated immunizations status.
        - Family History – a review of medical events in client's family including diseases which are hereditary or place the client at risk for disease.
        - Social History – age appropriated review of past and current activities, marital status, current employment, and sexual history.

5. Documentation

    a. Specific abnormal or relevant negative findings of the examination should be documented.
    b. Abnormal or unexpected findings of the examination should be described.
    c. A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings.

6. Number of Diagnosis, complexity of data, risk of complications.

    a. Document any records reviewed and results of tests completed.
    b. Document under "assessment" all diagnoses identified.

c. Update problem list to correlate with diagnoses.
d. Document under "plan" the treatment and any clinical radiological or medical tests ordered.
e. No provider except for a physician, nurse practitioner, or physician assistant may determine a level of complexity code or diagnosis.

7. How to identify "new" versus "established" clients.

   A new client is a client that has not been seen at the Division of Public Health Services within the last 3 years for a billable service, which involves a physical examination.

8. The Division of Public Health Services will use the most current ICD/CPT Coding books or approved electronic coding software when applying diagnoses and codes to services.

9. The original code documented by a provider may be revised, if needed, for reimbursement or accuracy purposes by another provider within that program. Consultation between the providers about the issues of the code must be discussed prior to the changes being amended and the change must be an approval by the original code provider.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PHYSICIAN CREDENTIALING

DATE DEVELOPED: 4/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

Orders are accepted by physicians licensed and in good standing with the State Board of Medical Examiners of State Boards of Medicine in the state of their "hands on" practice. Any individual representing himself/herself as a physician, who is not licensed, is reported to his/her state board for enforcement of the law.

II. PURPOSE:

To ensure that orders are received from properly credentialed physicians in good standing with their governing state boards.

III. GUIDELINES:

A. The quality of care provided to agency clients shall be comparable to that provided to inpatients, ambulatory care clients and emergency care clients. The Division of Public Health Services will follow this protocol.

1. If any clients are referred by a physician who has not had a credential verification updated within the past 12 months, the program supervisor shall request the Staff Development Coordinator to verify his/her credentials.

2. A listing obtained from the N.C. Medical Board for Rockingham County will be maintained which identifies current physicians in good standing to practice in this state. If a physician's name does not appear in the listings, verbal verification of credentials will be obtained by the Staff Development Coordinator, or a designee, from the state medical board and documented.

3. A current physician listing may be obtained from hospitals in the service area will be obtained annually for updates of physician's status.

B. North Carolina Verification

1. The Staff Development Coordinator contacts the North Carolina Medical Board (via website or telephone) to verify a physician's credentials. The following information is received:

    a. License number
    b. Issue date
    c. Expiration date
    d. In good standing with the Board

2. After verification of physician's licensure, the information is housed in the Staff Development Coordinator's office.

C. Definitions:

1. Physician – a doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery in the state of practice.

2. Intern – Doctor serving as assistant to resident in a hospital the first year after graduation.

    Intern does not have their own license and may not sign orders. They are practicing under their attending physician's license.

3. Resident – A person of advanced, specialized medical or surgical training in a hospital.

    Residents in North Carolina have their own temporary license and may sign orders.

4. Fellow – Licensed physician obtaining further training for specialized care.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT DISMISSAL

DATE DEVELOPED: 6/27/2012
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18; 6/23

I. POLICY:

The Division of Public Health Services may dismiss a client who is a safety threat to staff, other clients, and/or themselves.

II. PURPOSE:

To establish a procedure for the dismissal of clients from the Division of Public Health Services.

III. GUIDELINES:

A. Provider may recommend a client for dismissal from the Division of Public Health Services. Reasons for dismissal are not limited to, but may include:

- Non-Compliance
- Aggression or violent behavior exhibited during visit
- Chronic missed appointments
- Dishonesty/Stealing supplies
- Other, as deemed necessary

B. The Dismissal Policy will be provided to all clients at the initiation of services and via the website.

C. The Provider must keep detailed and accurate documentation of all events leading up to the recommended dismissal.

D. Providers must discuss the situation with the Director of Nursing and another Provider within the agency and receive the Medical Director's approval before dismissal can occur.

E. All concerns with noncompliance must be discussed with the client by the Provider at the appointment and documented in the client's medical record.

F. Once a decision to dismiss the client has been made, the Provider needs to speak directly to the client unless the Provider's safety is in question. The client must be offered 30 days of interim care and an alternate provider listing may be provided. If safety of staff is an issue, alternate arrangements

for care may be provided. If the client has broken the law with the agency they will be dismissed and prosecuted (i.e., prescription fraud).

G. The client should be informed and understand that he/she can still access other services of the Health Department that are required by law or Federal Funding guideline (e.g., Immunizations, Family Planning if client qualifies). Offer to transfer client records to new provider after written permission is obtained.

H. A certified letter will be sent from the Provider notifying the client of dismissal from the specific service here at the Division of Public Health Services. The letter will state that services will be terminated after 30 days, noting the specific date. A copy of the letter is scanned into the EHR.

I. Inform clinic staff to place note on demographic screen in the system regarding the service from which the client is dismissed. Clinic staff will be informed on a need to know basis.

Rev/di

Rockingham County Department of Health and Human Services

Division of Public Health Services
(336) 342-8140
PO. Box 204, Wentworth, NC 27375-0204
FAX (336) 342-8356

Date: _____

Dear: _____

This letter is to inform you of your discharge from the Adult Health Services at Rockingham County Division of Public Health. We are no longer able to meet your health care needs.

All of our providers have evaluated your condition(s) and have agreed that the scope of care needed for your medical condition(s) extend beyond our capabilities to provide. We are encouraging you to find another primary care provider. We will send your medical records to your new provider with a signed consent from you.

Sincerely,

_____
Kevin P. Howard, M.D.
Consulting Physician

_____
Olaf Massenburg, PA-c

_____
Rochelle Muse, PA-C

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT AND COUNTY EMPLOYEE EVALUATION

DATE DEVELOPED: 4/27/98
REVIEWED: 6/16; 6/17; 6/18; 9/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 9/18; 6/23

I. POLICY:

The Division of Public Health Services will provide a safe and effective evaluation program for the clients or employees who call or visit. A safe, effective evaluation program will provide information and referral based on need and availability of service. No client or employee will be without education, advice, treatment, or referral.

II. PURPOSE:

The purpose of an evaluation system is to collect or evaluate and prioritize client or employees health problems, educate and advise and make safe, effective, and appropriate dispositions by telephone or face-to-face encounters with the client or employee. Information is also collected to determine the urgency of a health problem and to determine whether medical intervention is needed and how soon treatment should begin.

III. GUIDELINES:

A. Nurses will demonstrate the knowledge and skills necessary to provide safe and effective nursing care, whether performing telephone evaluation or by evaluating and advising the client in the clinic setting. This position may be staffed by a Registered Nurse or a Licensed Practical Nurse under the supervision of a Registered Nurse.

B. The Division of Public Health Services has adopted the guidelines for adult triage as published in David A. Thompson, MD, FACEP Adult Telephone Protocols, Office Version, 2nd Edition, 2009.

C. The Barton D. Schmitt, MD's Pediatric Telephone Protocols, 2006 11th Edition will be utilized in the Child Health Program. This protocol manual is distributed by the American Academy of Pediatrics. These protocols will be used by the nurse in the management of walk-in pediatric clients.

D. Goals

1. Clinic Goals

a. Walk-in clients that are established with the Agency will be placed into any open slot and will not see the triage nurse for

evaluation. An open slot is any slot that has been cancelled, rescheduled, or a "no show" after 15 minutes.

b. Provide appropriate evaluation of clients/employees and proper disposition: the nurse is to obtain not only a history of current complaints from the client, but also a full set of vital signs, including TPR, BP, pain level, and weight as the nurse deems necessary.

If the nurse's evaluation does not indicate the need for the extenders to evaluate the client, the nurse is to document what other counter treatments are recommended, if any, and any appointments made, following the nurse's interaction with the client, in the electronic health record (EHR).

If the nurse determines that the client needs to be seen that day or immediately, if an appointment is available, place in the time slot. If no appointment is available see clinic supervisor to work in where appropriate.

Walk-in triage or triage calls for Family Planning and STD are to go to Family Planning. The triage nurse is to document in the EHR.

c. Provide crisis intervention and referral
d. Provide referrals
e. Provide advice for:
- home treatment of routine health-care problems
- first aid
- nursing interventions

2. Telephone Goals

a. Utilize the nursing process:
   i. Evaluation:
      - elicit data in sufficient quantity, quality, and detail
      - establish a sequence of events relating to the presenting symptoms
   ii. Establish
      - is there a problem
      - is there a potential problem
      - is the client/employee handling it well or does he/she need help
      - does the problem need to be studied further
      - does the problem sound serious
      - is the problem urgent or emergent
   iii. Disposition
      - home treatment

- referral to clinic/healthcare provider if a telephone evaluation client is scheduled to see a physician extender that same day, the LPN/RN/MOA assigned to the physician extender is responsible for working up that client for the physician extender or the triage nurse if the LPN/RN/MOA assigned to the provider is busy. All documentation occurs in the EHR.
- emergency treatment
- counseling
- reassurance

b. Establish with the client or employee a mutual understanding about the terms of the intervention.

c. Ask client or employee to write down instructions if there is a chance that they will not remember. In all cases ask the client or employee to repeat back your instructions.

- evaluation
  - explain to the client/employee the expected normal course of events in the next few hours or days, possible complications and a time frame within which to call back if there is a failure to improve.
  - instruct client/employee to call back if further questions arise, symptoms worsen, or home treatment fails to work.

E. Procedure

1. When a call is received, the receptionist will retrieve demographic information and client/employee symptoms and document these in the EHR.

   a. If the caller is at a pay phone or a phone that he/she will be available at for a limited amount of time, then the receptionist will forward the call to the appropriate nurse (triage/family planning).

   b. There may be situations when calls will be forwarded to the nurse as they are received. Examples may be:

      - Physician's offices
      - Pharmacy

2. The nurse will be responsible for retrieving the calls from voice mail and returning the call to the clients.

3. The nurse will contact the caller and obtain further information.

a. As the nurse is screening the complaints he/she will reference the triage protocols as listed previous according to the age of the client.
b. Based on information received, the triage nurse will:

- Schedule the client to be seen in the appropriate clinic
- Advise them according to protocols per the agency to standing orders
- Make outside referral to appropriate disciplines or agencies

c. If there are available clinic slots for the day, the client is scheduled to come in – and the triage process is not indicated.
d. Any client that calls in for advice needs to be assessed if they are a current Health Department client.

- If they are not, they should be given the option to become a Health Department client & referred to their provider
- Or, schedule them to be seen in the clinic

However, no clinical, medical advice should be given over the phone to any person who is not a Health Department client. The nurse should not render opinions regarding diagnosis or treatment over the telephone.

4. County Employees Only:

a. Employee will consult with their Department Head.
b. If the nature of the problem is not an emergency, the employee will schedule an appointment with the Wellness Clinic. If the Wellness Clinic is unavailable the Department Head/Designee will call the Division of Public Health Services to schedule a time for the employee to be seen in the clinic. Walk-ins are not accepted.
c. All attempts will be made for the employee to be seen in the Wellness Clinic but if the employee is unable to be seen, the employee will be triaged in the Division of Public Health Services' clinic per protocol.
d. Employee will register at the registration desk and a nurse will see employee to gather information about the illness/injury. Any employee who sustains an injury on the job should call their supervisor to report the incident and receive instruction. The Safety Risk Manager should also be notified at 336-588-5302.

e. It will be determined at that time if the employee can be served adequately in the clinic or if he/she should be referred.
f. Referrals will be made according to the nature of the problem and to a designated physician.
g. Documentation will occur in the EHR.

F. Follow-up

The nurse will determine which clients may require follow-up.

1. This will be indicated by pending the note in the EHR to the triage nurse for follow-up.

2. The nurse may call the client/employee to assess compliance of any previous instructions given.

3. Follow-up documentation will be made in the EHR.

   a. Documentation must be thorough
   b. Document client/employee response; agree/disagree, know how and when to call back

4. This last step will assure us that the client has:

   a. Understood instructions
   b. Followed instructions, and
   c. Received the proper treatment

G. Documentation -

All triage assessment/calls are documented in the EHR.

H. Duty of Care:

1. Once you begin to give advice, your legal duty begins. The nurse must either give appropriate advice or a referral and not just terminate the call.

2. Do not end the call until there is an agreement to plan between the caller and the nurse taking the call.

3. Do not refuse to speak with a caller.

4. Do not:

   a. Place the caller on hold for an extended period of time
   b. Delay in responding to the caller

5. Overcome any language barriers by:

    a. If unable to communicate effectively over the phone, have the client come into the health department for interpreters.
    b. Be receptive, give reassurance, and be available.

J. Other Considerations for Telephone Evaluation:

1. The nurse should use clear and unambiguous terms to make sure the caller is aware of dangers of non-compliance.

2. If the nurse reasonably believes that the caller has the means to carry out an immediate threat – you should warn the provider and notify the police. Document carefully why you believe the caller's threat was imminent.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: STANDING ORDERS

DATE DEVELOPED: 1991; 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18; 6/23

I. POLICY:

The Division of Public Health Services has developed "Standing Orders" within the agency programs that will provide the framework for Registered Nurses and Licensed Practical Nurses who need clear Standing Orders which do not require any medical decision-making. All orders are written in NC Board of Nursing format.

II. PURPOSE:

A. Standing orders are the signed instructions of a provider which describe the parameters of specified situations under which the nurse may act to carry out specific orders for a client presenting with symptoms or needs addressed in the Standing Orders.

B. Standing orders outline the assessment and interventions that a nurse may perform or deliver.

III. GUIDELINES:

LPN's and RN's function under standing orders in situations where they are allowed to determine whether specified conditions exist, and in which intervention is allowed by medically established guidelines, in the Health Department setting where no physician is present.

A. The Registered Nurse and Licensed Practical Nurse are only able to assess and treat diseases and/or conditions using standards in the form of standing orders. Any situation that falls outside the written standard (e.g., standing order) must be referred to a Physician/Advanced Practice Provider (APP).

B. Registered Nurses and Licensed Practical Nurses must follow "standards" defined as standing orders in order to assess and treat disease in local health departments. "Standards" must be written in a manner that does not allow nurses to make medical judgments or decisions.

C. A nurse carrying out medical "Standing Orders" in which the nurse is allowed to determine, based on parameters identified in the standing order, whether a specified condition exists, thus indicating the need to execute the

orders, generally recognized as functioning within professional nursing practice. It has been determined to be within the scope of the practice for nurses to perform certain services which have been prescribed, dated and signed by a physician, by the NC Board of Nursing and also accepted as such in the Medical Act.

D. Legal Basis for Standing Orders

1. According to the NC Board of Nursing, the citation that permits registered nurses to function under Standing Orders is G.S. 90-171.20(7)(f) and the Nursing Practice Act State of North Carolina.

2. The Division of Public Health Services' Standing Orders are written, dated, and signed by a physician licensed to practice in North Carolina. They are reviewed at least annually and revised as necessary. The registered nurse who follows medical standing orders applicable to factual situations and who is qualified to recognize these situations is not engaging in medical practice.

3. The Division of Public Health Services' Standing Orders are necessary for clinical services during which medical treatment or medication(s) may be indicated. The physician or medical consultant may sign the Standing Orders for nursing services. They are specific to each clinic service (i.e., family planning, child health, maternity, immunization, etc.). Standing orders describe the parameters of specified situations under which the nurse may act. These services may include but are not limited to:

   a. Administering of immunization agents.
   b. Administering of recommending treatment for rash, head lice, scabies, etc.
   c. Administering vitamins or iron preparations.
   d. Administering of Oxygen and or Adrenalin in emergency situations.
   e. Administering Immune Serum Globulin in order to prevent Hepatitis A after client is exposed. In an outbreak situation the physician will issue orders to administer IG according to the Communicable Disease Manual recommendations.

4. The RN/LPN will not use Standing Orders to discriminate assessment findings beyond the level of normal vs. abnormal (i.e., to diagnose based on non-objective assessment findings.) Such activity is beyond the legal scope of practice for the RN. Areas where standing orders may require such discrimination include:

   a. otitis media
   b. otitis externa

c. respiratory infections
d. urinary tract infections
e. bronchitis
f. tonsillitis
g. strep throat unless the decision to treat is based solely on:
-subjective data
-positive lab findings

5. The agency standing orders are reviewed annually and prn for any revisions needed. Each program area reviews their specific standing orders. The standing orders are reviewed, approved and signed by the Medical Director. The Standing Orders may be co-signed by the Program Consulting Physician also.

E. Components required for use of standing orders may include:

1. Policy statement regarding the activity, including:

a. Specific components of broad, generic practice activity
b. When/where an activity may be performed
c. Limitations/exclusions as necessary

2. Identification of those who may be eligible to perform the activity, including:

a. Level(s) of licensure required
b. Types/amounts of previous experience required
c. Required time as employees in current position
d. Educational requirements in addition to licensure

3. Training and supervised clinical practice requirements, including:

a. Classroom content
b. Skilled lab activities
c. Supervised clinical practice requirements
d. Skill maintenance requirements
e. Evaluation process to validate competency

Current copies of Standing Orders may be kept by the program coordinator/ supervisor in a loose-leaf binder. The current original Standing Orders are maintained by the Director of Nursing. All Standing Orders may be viewed online in the "T" drive folder.

References: Nurse Practice Act, G.S. 90-171.20(7)(f)

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MEDICAL CONSULTANT/SUPERVISING PHYSICIANS

DATE DEVELOPED: 1/06
DATE REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
DATE REVISED: 6/16; 6/18; 6/23

I. POLICY:

The Division of Public Health Services shall ensure adequate medical consultation of the clinical services provided.

II. PURPOSE:

The Division of Public Health Services contracts with a medical consultant (a physician licensed to practice medicine in North Carolina) when the health director is not a physician licensed to practice medicine in North Carolina.

III. GUIDELINES:

A. The medical consultant shall have the following responsibilities not otherwise assured by a licensed physician associated with the health department.

1. Approving, by signature, all medical procedures adopted by the Division of Public Health Services.

2. Consulting with the Division of Public Health Services' staff in the resolution of unanticipated medical problems as they arise.

3. Ensuring through consultation and review that the quality of medical services provided by the Division of Public Health Services meets current medical standards of care.

4. Providing all other medical supervision required by Public Health Laws and the Division of Public Health Services' programs.

B. RULES FOR SUPERVISION OF PHYSICIAN ASSISTANTS

- 21 NCAC 32S .0213 SUPERVISION OF PHYSICIAN ASSISTANTS

(a) A physician wishing to serve as supervising physician shall exercise supervision of the physician assistant in accordance of the rules adopted by the Board.
(b) A physician assistant may perform medical acts, tasks, or functions only under the supervision of a physician. Supervision shall be continuous but, except as otherwise provided in the rules of this Subchapter, shall

not be construed as requiring the physical presence of the supervising physician at the time and place that the services are rendered.

(c) Each team of physician(s) and physician assistant(s) shall ensure that the physician assistant's scope of practice is identified; that delegation of medical tasks is appropriate to the skills of the supervising physician(s) as well as the physician assistant's level of competence; that the relationship of, and access to, each supervising physician is defined; and that a process for evaluation of the physician assistant's performance is established.

(d) Each supervising physician and physician assistant shall sign a statement, as defined in Rule .0201(8) of this Subchapter, that describes the supervisory arrangements in all settings. Written prescribing instructions are required for each approved site. This statement shall be kept on file at all practice sites, and must be available upon request by the Board.

(e) A primary supervising physician and a physician assistant in a new practice arrangement shall meet monthly for the first six months to discuss practice relevant clinical issues and quality improvement measures. Thereafter, the primary supervising physician and the physician assistant shall meet at least once every six months. A written record of these meetings shall be signed and dated by both the supervising physician and the physician assistant, and shall be available for inspection upon request by the Board agent. The written record shall include a description of the relevant clinical issues discussed and the quality improvement measures taken.

History Note: *Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;*

- 21 NCAC 32S .0215 RESPONSIBILITIES OF PRIMARY SUPERVISING PHYSICIANS IN REGARD TO BACK-UP SUPERVISING PHYSICIANS

(a) The primary supervising physician shall ensure that a supervising physician, either primary or back-up, is readily accessible for the physician assistant to consult whenever the physician assistant is performing medical acts, tasks, or functions.

(b) A back-up supervising physician must be licensed to practice medicine by the Board, not prohibited by the Board from supervising a physician assistant, and approved by the primary supervising physician as a person willing and qualified to assume responsibility for the medical acts performed by the physician assistant in the absence of the primary supervising physician. A current list of all approved back-up supervising physicians, signed and dated by each back-up supervising physician, the primary supervising physician, and the physician assistant, must be retained as part of the Supervisory Arrangement.

History Note: Authority G.S. 90-18(c)(13); 90-18.1; Eff. September 1, 2009.

- 21 NCAC 32S .0216 CONTINUING MEDICAL EDUCATION

(a) A physician assistant shall complete at least 50 hours of Continuing Medical Education (CME) every two years. The CME shall be recognized by the National Commission on Certification of Physician Assistants (NCCPA) as Category I CME. The physician assistant shall provide CME documentation for inspection by the Board or its agent upon request. The two-year period shall begin on the physician assistant's birthday following the issuance of his or her license.

(b) A physician assistant who prescribes controlled substances shall complete at least two hours of CME, from the required 50 hours, designed specifically to address controlled substance prescribing practices. The controlled substance prescribing CME shall include instruction on controlled substance prescribing practices and controlled substance prescribing for chronic pain management. CME that includes recognizing signs of the abuse or misuse of controlled substances, or non-opioid treatment options shall qualify for purposes of this Rule.

(c) A physician assistant who possesses a current certification with the National Commission on Certification of Physician Assistants (NCCPA) shall be deemed in compliance with the requirement of Paragraph (a) of this Rule. The physician assistant shall attest on his or her annual renewal he or she is currently certified by the NCCPA. Physician assistants who attest he or she possesses a current certificate with the NCCPA shall not be exempt from the controlled substance prescribing CME requirement of Paragraph (b) of this Rule. A physician assistant shall complete the required two hours of controlled substance CME unless the CME is a component part of their certification activity.

History Note: Authority G.S. 90-5.1(a)(3); 90-5.1(a)(10); 90-18.I; S.L. 2015-241, 12F.16(b) and 12F.16(c); Eff. September 1, 2009;
Amended Eff. May 1, 2015; November 1, 2010;
Pursuant to G.S. 150B-21.3A rule is necessary without substantive public interest Eff. March 1, 2016;
Amended Eff. April 1, 2020; September 1, 2016.

C. RULES FOR SUPERVISION OF NURSE PRACTITIONER

- 21 NCAC 32M .0102 SCOPE OF PRACTICE

The nurse practitioner's scope of practice is defined by academic educational preparation and national certification and maintained competence. A nurse practitioner shall be held accountable by both Boards

for a broad range of personal health services managing patient care for which the nurse practitioner is educationally prepared and for which competency has been maintained, with physician supervision and collaboration as described in Rule .0110 of this Subchapter. These services include:
(1) promotion and maintenance of health;
(2) prevention of illness and disability;
(3) diagnosing, treating and managing acute and chronic illnesses;
(4) guidance and counseling for both individuals and families;
(5) prescribing, administering and dispensing therapeutic measures, tests, procedures and drugs;
(6) planning for situations beyond the nurse practitioner's scope of practice and expertise by consulting with and referring to other health care providers as appropriate; and
(7) evaluating health outcomes.

History Note: Authority G.S. 90-5.1(a)(3); 90-18(c)(14); 90-18.2;
Eff. January 1, 1991;
Amended Eff. August 1, 2004; May 1, 1999; January 1, 1996;
Pursuant to G.S. 150B-21.3A ruse is necessary without substantive public interest Eff. March 1, 2016;
Amended Eff. June 1, 2021

- 21 NCAC 32M .0110 QUALITY ASSURANCE STANDARDS FOR A COLLABORATIVE PRACTICE AGREEMENT

The following are the quality assurance standards for a collaborative practice agreement:
(1) Availability: The primary or back-up supervising physician(s) and the nurse practitioner shall be continuously available to each other for consultation by direct communication or telecommunication.
(2) Collaborative Practice Agreement:
    (a) shall be agreed upon and signed by both the primary supervising physician and the nurse practitioner, and maintained in each practice site;
    (b) shall be reviewed at least yearly. This review shall be acknowledged by a dated signature sheet, signed by both the primary supervising physician and the nurse practitioner, appended to the collaborative practice agreement and available for inspection by members or agents of either Board;
    (c) shall include the drugs, devices, medical treatments, tests and procedures that may be prescribed, ordered and performed by the nurse practitioner consistent with Rule .0109 of this Subchapter; and
    (d) shall include a pre-determined plan for emergency services.
(3) The nurse practitioner shall demonstrate the ability to perform medical acts as outlined in the collaborative practice agreement upon request by members or agents of either Board.

(4) Quality Improvement Process:

(a) The primary supervising physician and the nurse practitioner shall develop a process for the ongoing review of the care provided in each practice site including a written plan for evaluating the quality of care provided for one or more frequently encountered clinical problems.

(b) This plan shall include a description of the clinical problem(s), an evaluation of the current treatment interventions, and if needed, a plan for improving outcomes within an identified time-frame.

(c) The quality improvement process shall include scheduled meetings between the primary supervising physician and the nurse practitioner at least every six months. Documentation for each meeting shall:

(i) identify clinical problems discussed, including progress toward improving outcomes as stated in Sub item (4)(b) of this Rule, and recommendations, if any, for changes in treatment plan(s);

(ii) be signed and dated by those who attended; and

(iii) be available for review by members or agents of either Board for the previous five calendar years and be retained by both the nurse practitioner and primary supervising physician.

(5) Nurse Practitioner-Physician Consultation. The following requirements establish the minimum standards for consultation between the nurse practitioner and primary supervising physician(s):

(a) During the first six months of a collaborative practice agreement between a nurse practitioner and the primary supervising physician, there shall be monthly meetings for the first six months to discuss practice relevant clinical issues and quality improvement measures.

(b) Documentation of the meetings shall:

(i) identify clinical issues discussed and actions taken;

(ii) be signed and dated by those who attended; and

(iii) be available for review by either Board for the previous five calendar years and be retained by both the nurse practitioner and primary supervising physician.

History Note Authority G.S. 90-8.1; 90-8.2; 90-18(14); 90-18.2; 90-171.23(14);
Amended Eff. June 1, 2021

- 21 NCAC 32M .0107 CONTINUING EDUCATION (CE)

In order to maintain nurse practitioner approval to practice, the nurse practitioner shall earn 50 contact hours of continuing education each year beginning with the first renewal after initial approval to practice has been granted. At least 20 hours of the required 50 hours must be those hours for which approval has been granted by the American Nurses Credentialing

Center (ANCC) or Accreditation Council on Continuing Medical Education (ACCME), other national credentialing bodies, or practice relevant courses in an institution of higher learning.

Every nurse practitioner who prescribes controlled substances shall complete at least one hour of the total required continuing education (CE) hours annually consisting of CE designed specifically to address controlled substance prescribing practices, signs of the abuse or misuse of controlled substances, and controlled substance prescribing for chronic pain management. CE that includes recognizing signs of abuse or misuse of controlled substances, or non-opioid treatment options shall qualify for purposes of this Rule. Documentation shall be maintained by the nurse practitioner for the previous five calendar years and made available upon request to either Board.

History Note: Authority G.S. 90-5.1; 90-8.1; 90-8.2; 90-14(a)(5); S.L. 2015-241, s. 12F; Eff. January 1, 1996; Amended Eff. June 1, 2021

D. Quality Improvement:

The primary supervising physician and the Advanced Practice Provider (APP) shall develop a process for the ongoing review of the care provided in each practice site including a written plan for evaluating the quality of care provided for one or more frequently encountered clinical problems.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CAROLINA ACCESS – PRIMARY CARE AND AFTER HOURS WEEKEND COVERAGE

DATE DEVELOPED: 2/98
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18; 6/19; 6/23

I. POLICY:

The Division of Public Health Services participates in the CAROLINA ACCESS PROGRAM to provide primary care services to all participating Medicaid members that enroll with the Division of Public Health Services as a Primary Care Provider (PCP).

II. PURPOSE:

To act as a "gate-keeper" for the Medicaid enrollee assigned to the Division of Public Health Services to receive primary care services and to provide coverage for Carolina Access clients during hours that the Health Department is closed.

III. GUIDELINES for PRIMARY CARE:

A. It is the purpose of the Carolina Access program to provide Medicaid recipients with the most efficient and cost saving health care in order to meet the needs of the client.

B. It is the intent to reduce visits to local hospital emergency rooms for primary care services that could be rendered by the Primary Care Provider.

C. Eligible recipients enroll into Carolina Access Program through a certification process with the Division of Social Services. The enrolled recipients are educated at that time about the Carolina Access Program.

D. The enrolled recipient is given a participation Medicaid card that details the name of their chosen Primary Care Provider and phone number. To verify Medicaid eligibility and Carolina Access enrollment, you can use the automated voice response system at 1-800-723-4337.

E. Carolina Access Primary Care Providers are required to adhere to the following guidelines to receive reimbursement for services.

1. Carolina Access Primary Care Providers must provide routine well care within 90 days of presentation or notification (15 days for pregnancy), routine sick care within 3 days of presentation or

notification, urgent care within 24 hours of presentation or notification and emergency care immediately upon presentation or notification.

2. Carolina Access Primary Care Providers must provide prompt access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service, when appropriate, 24 hours per day, 7 days per week. Prompt is defined as one hour. The Division of Public Health Services' telephone system provides a recording in English and Spanish directing the Carolina Access enrollee how to reach the on-call registered nurse or advanced practice provider (APP).

3. Carolina Access Primary Care Providers must have a provider available in the office to see clients a minimum of 30 hours per week. (Refer to Section 4.6 of the Agreement).

4. Other requirements from the Primary Care Provider are:

   a. To authorize referrals for necessary specialist care.
   b. To review and reinforce important information to enrollees regarding:

      - Do not go the emergency department unless you have a life threatening condition.
      - Make and keep all medical appointments or call ahead to cancel.

   c. The following should be addressed with each new enrollee:

      - The Primary Care Providers requirement to provide medical advice and care 24 hours per day, 7 days per week and the preferred method for contacting the primary care provider.
      - The enrollee's responsibility to bring his/her current month's Medicaid card to each appointment.
      - The enrollee must contact primary care provider for a referral before going to any other doctor.
      - The enrollee must contact the primary care provider before going to the emergency department unless the enrollee feels his/her life or health is in immediate danger.
      - The importance of regular preventive care visits such as Health Check screening for children immunizations, checkups, mammographies, cholesterol screenings, adult health assessments and diabetic screenings.

- Co-payment requirements
- The availability of additional information from county Department of Social Services.

Primary care providers should review enrollee utilization and cost reports and advise the program of errors.

5. Providers are responsible for verifying Medicaid eligibility when a recipient presents for services. This should be done at each visit because the enrollee's eligibility status or primary care provider may have changed.

6. Standards of appointment availability:

   Primary Care Providers must conform to the following standards for appointment availability:

   - emergency care – immediately upon presentation or notification
   - urgent care – within 24 hours of presentation or notification
   - routine sick care – within 3 days of presentation or notification
   - routine well care – within 90 days of presentation or notification

7. Standards for office wait times:

   Primary Care Providers must conform to the following standards for office wait times:

   - walk-ins – within 2 hours or schedule an appointment within the standards of appointment availability.
   - scheduled appointment – within one hour
   - life-threatening emergency – must be managed immediately.

F. Carolina Access Provider agrees to provide the following clinical services for Adult Medicaid enrollees: PRIMARY CARE

1. Are clients 21 years of age and/or older.

2. Adult Medicaid Carolina Access clients may receive <u>ONE</u> preventive annual health assessment per year, every 365 days. (Staff please verify)

3. According to the North Carolina Medicaid Program Guidelines – a Preventive Annual Health Assessment provides an assessment with the expectations that it will prevent serious illness through early detection and treatment.

4. Physician assistants, nurse practitioners, and registered nurses employed by the Division of Public Health Services who have completed the adult health physical assessment course, may provide the annual health assessment. The extent of the assessment depends on individual client and presenting and exhibiting complaints.

5. The components of an initial adult annual health assessment for a new client are as follows:

   a. Comprehensive health history to include present, past and family history. History information is obtained on the initial visit and updated as necessary. Examples of history components may include:

      - Present history – potential risk factors, alcohol, drug and tobacco use, highway safety, sexual practices, family violence, exercises and nutritional habits, medications, review of systems and symptoms.
      - Past history – Immunizations, diphtheria, tetanus, polio, rubella, influenza, pneumococcal, and hepatitis vaccines, significant illness, blood transfusions.
      - Family history
      - Environmental exposures – sun or radiation exposures, exposure to carcinogens, noise.

   b. A comprehensive physical examination must be performed and includes:

      - The following will be recorded on the charts at each visit
        - height, weight, blood pressure, pulse
        - a complete inspection of skin, oral cavity, EENT, heart, abdomen, breast (female), pelvic, rectal, testicular (male), and extremities

   c. Gender, age, and medically appropriate lab/diagnostic procedures to correlate with identified problems or presenting symptoms.

      - Routine labs to include: hematocrit, urinalysis and pap smears.
      - Additional tests must have a supporting need and diagnosis.
      - PPD's and hemoccults may be strongly recommended however, there may be additional charges associated.

The following components may be billed as separate procedures when performed as part of the preventive annual health assessment:

- injectable medications
- ancillary studies for laboratory and radiology

These are the only CPT codes that are separately billed when an annual health assessment is performed.

d. Counseling, anticipatory guidance, risk factor reduction interventions include:

- Risk factors for cancer, hypertension, cardiovascular disease, trauma, communicable disease, and addictive behaviors discussed and documented.
- Individualized plan of care and treatment developed in consultation with the client.
- Instructions for self-examination for breast, testes, and skin.

G. Health Check Pediatric Primary Care

1. This primary care is intended for recipients of Medicaid, birth to age 21.

2. The Health Check Medical Screening Exam is a comprehensive preventive service at specific age-appropriate intervals. A Health Check screening is the only well-child preventive visit reimbursable by Medicaid.

3. This agreement requires the Division of Public Health Services to provide the results of the exam to the PCP within 30 days unless follow-up is necessary, then the Division of Public Health Services must communicate the results of the screening within 24 hours to the above named physician providers.

4. The Division of Public Health Services must perform all health check components during the exam unless findings relevant to the visit require an appointment to be rescheduled.

5. The Division of Public Health Services is to submit the following to the client's contracted primary care provider:

- The Division of Public Health Services must provide the age appropriate Health Check exam and immunizations within

ninety (90) days of the request for clients who are referred by the PCP or self-referred.

- The Division of Public Health Services will send the Health Check physical exam and immunization records monthly to the Primary Care Provider.
- Notify the Primary Care Provider of significant abnormal findings on the Health Check exam within (24) hours. Allow the primary care provider to direct further referrals for specialized testing or treatment.

6. The Health Check Program is a preventive program for Medicaid eligible children ages birth to 20.

H. REFERRAL FOR OUTSIDE SERVICES

1. All Division of Public Health Services' clients, Medicaid enrolled in Carolina Access, as our agency being the Primary Care Provider, may be referred to an outside provider for extended services to be provided in which the Division of Public Health Services cannot provide due to the client's needs requiring further care outside the scope of the APPs employed by the Division.

2. The following referral process must be conducted when approving services for all outside providers. Individual responsibilities include:

   a. If a client is seen by an APP at the Division of Public Health Services and requires extended medical care beyond their scope of practice, the client will be referred to a specialist or follow-up physician.
   b. A referral form must be completed to authorize the referral process.
   c. If a call comes into the health department from an outside provider that is treating or has treated a client that is enrolled with Carolina Access and lists the Division of Public Health Services as the primary care provider, before authorizing with the release of our number, you must discuss the request with the Division of Public Health Services' primary care provider of that client and complete a referral form.
   d. When all calls are received into the health department requesting the authorization number, the following individuals should only process the calls.
   Following order:

   Designee from Management Support
   Management Support Supervisor
   Adult/Child Health Clinic Supervisor

Under no circumstances should anyone other than the above named positions process release the authorization Medicaid Number.

e. Once the practitioner has reviewed the request and the client's clinical record; a Division of Public Health Services' Referral Form will be completed and must contain the following information:

- Diagnosis
- Treatment to be rendered
- The name of the treating physician
- The number of visits required to this treating physician

f. The outside provider must receive this information before they can bill Medicaid for services.

g. The original referral must be sent to the outside follow-up physician and a copy is scanned into the client clinical record.

h. Referral Documentation: All referrals must be documented in the enrollee's medical record.

i. Clients who have not been seen at the Division of Public Health Services in three or more years will be considered a new patient.

I. A Carolina Access client may change their primary care provider for Medicaid Direct only by contacting their case manager at the Division of Social Services. Clients with a Prepaid Health Plan (PHP) should contact the PHP to change primary care provider.

J. The Division of Public Health Services may request to transfer or disenroll the client as a Carolina Access enrollee by contacting the case manager at the Division of Social Services or the PHP.

K. The Division of Public Health Services should have client contact DSS if they need to change the following:

1. Change in the clinic name
2. Change in the participating providers
3. Change in Medicaid provider number
4. Change in the Carolina Access contact person, telephone number or address

L. The following reports and data will be submitted to the Division of Public Health Services. Each should be reviewed for accuracy:

1. Monthly Enrollment Report – at the beginning of the month- use this to identify new clients that have been enrolled, our current clients enrolled, and clients that are no longer listed with the Division of Public Health Services as Carolina Access PCP.

2. Emergency Room Management Report – identifies claims that have been submitted from emergency rooms within the month. The Division of Public Health Services should review this report and educate clients to utilize their PCP at the health department rather than frequent ER visits. This report has three sections:

   a. True emergencies – claims paid
   b. Triage Assessments – clients who went to ER with a non-emergency assessed and referred to the PCP for treatment.
   c. Other ER claims – claims paid for non-emergencies

M. Duties of the Primary Care Provider for Carolina Access

1. To accept enrollees and to provide their primary health care needs as primary care provider.

2. To provide preventive services.

3. Maintain a client medical record.

4. Arrange referrals for medical necessary health care services that are not directly provided and document referral in the client's medical record.

5. Transfer the enrollee's medical record to the receiving provider upon change of PCP at the request of the new PCP and authorized by the enrollee within 30 days of the date of request.

6. Refer enrollee for second opinion if indicated.

7. Review all enrollee utilization and cost reports provided by the Carolina Access Program. Assess for errors, omissions, or discrepancies.

8. Provide the Medicaid Division or its authorized representative of the Federal Government unlimited access to all records under the Carolina Access agreement as required by Medicaid Policy and 42 C.F.R.431.107.

9. Refer enrollees to the WIC Program.

10. Refrain from discriminating against enrollees on the basis of health status, race, color, or national origin.

11. Makes oral interpretation services available free of charge to enrollees – to all non-English languages.

12. Refrain from door to door, telephone or other marketing.

13. Retain records in accordance with 45 C.F.R. 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the record is started before or during the original 3 year period ends.)

N. Hospital Admitting Requirement for Carolina Access clients

1. The Division of Public Health Services has a formal arrangement with the following practices for the management of inpatient hospital admissions that address the needs of all enrollees or potential enrollees.

2. This formal arrangement is defined by Medicaid as a voluntary agreement between the Carolina Access primary care provider and the agreeable hospital group. The agreeable party is committing in writing to admit and coordinate medical care for the Carolina Access enrollee through out the inpatient stay.

3. The following guidelines and practices must be met in order to comply with the hospital's admitting requirement.

   a. The Division of Public Health Services has submitted a signed Carolina Access Hospital Admitting Agreement to DMA.
   b. All ages of the enrollees must be covered by the inpatient hospital care or formal arrangement for inpatient hospital care.
   c. The Carolina Access Hospital Admitting Agreement Form must be between the Carolina Access PCP and one or more of the following:

      - a physician
      - a group practice
      - a hospital list group
      - a physician call group

   These providers must be enrolled as NC Medicaid providers, but it is not necessary that they be enrolled as Carolina Access providers.

Admissions through unassigned hospital based call groups do NOT meet this requirement.

d. Admitting privileges on the formal arrangement must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five (45) minutes drive time from the Carolina Access PCP's practice.

e. The Division of Public Health Services has agreements for the following to provide hospital admissions for enrollees of the Division of Public Health Services:

- A list of approved hospitals with hospitalist caring for enrollees.

O. Carolina Access – After Hours/Weekend Coverage

1. Coverage will be provided by the APP and registered nurses on a rotating basis.

2. Each staff member, providing call coverage, will be issued a cellular phone for on-call assignment.

3. The health department telephone number is listed on the client's Carolina Access Medicaid Card. After hours and on weekends when the client calls this number he/she will be given another number to call. The nurse/extender will return the call within one hour per Carolina Access Protocol.

4. The calls are triaged according to Carolina Access Triage Protocols. The client is advised:

   a. as to home treatment
   b. given a time (appointment) to come into the clinic during operational hours
   c. or routed to the emergency department of the nearest hospital (if critical lab value received or nursing judgment deems necessary)

5. When the client is referred to the ED the hospital may be notified by the on-call nurse. All calls are documented and reviewed by the nursing supervisor and forwarded to the APP as necessary. Follow-up is provided for continuity of care.

6. Clients under Carolina Access are no longer required to seek prior approval from the health department staff before being seen in the emergency room.

7. The Carolina Access on call nurse will receive any communicable disease call after hours, weekends or holidays. The following information will be required during the referral process:

    a. The name of the suspected or confirmed communicable disease.
    b. Number of people associated with the outbreak.
    c. Name of the attending physician.
    d. Name, title, and telephone number of the reporting individual.

    After information obtained contact the Communicable Disease Coordinator via telephone at (336) 589-5715 or Public Health Preparedness Coordinator via telephone at (336) 420-5408.

8. Notification to Primary Care Physician

    a. The Division of Public Health Services is not obligated to contact physicians who are primary Care Providers.
    b. However, it is requested that we make a courtesy call to that PCP and inform them that their client is here for a service.
    c. The Physician (PCP) may approve or disapprove of seeing their client.
    d. As a health department we are exempt from requiring approval to see their client.
    e. If the client wishes to continue to be seen at the Division of Public Health Services, staff should inform the client of the process to have their listed PCP changed on their Medicaid Card. The client will need to have this change through Department of Social Services before the Division of Public Health Services provides services.
    f. When a triage client presents for services to the Division of Public Health Services, a staff member will place a call to the PCP to retrieve any medical information that may be pertinent to the client's care rendered, such as current medication the client is taking, any allergies, and/or any specific contraindications listed. Document any findings retrieved.
    g. If no information is given to the Division of Public Health Services and the physician's office refuses to give approval, document this and inform the client of their need to choose their PCP. Document all information exchanged during the encounter.

9. Staff Reimbursement for providing on-call coverage

a. Reimbursement rates are a flat rate per day for carrying the phone and providing triage services.
b. Reimbursement amounts of $20.00 per workday or per weekend day and $25.00 for holidays on which the health department is closed.

10. Coverage

a. Call begins on Tuesday at 5:00 pm and ends on the next Tuesday at 8:00 am.
b. Call time is rotated by the Registered Nurses and APP.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CONTRACTS FOR SCHOOLS OF PROFESSIONAL CURRICULUM

DATE DEVELOPED: 10/98
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/18

I. POLICY:

To encourage nursing/pharmacy students to obtain a wide range of knowledge relating to community health services.

II. PURPOSE:

Schools of Nursing and other schools of allied health services may choose the Division of Public Health Services for the Community Health Clinical site experience during the nursing program practicum.

III. GUIDELINES:

A. The nursing students may consist of the following:

1. Generic nursing students in the RN and LPN programs
2. RN/BSN nursing students
3. Masters prepared nursing students
4. Nurse Practitioner nursing students

B. The allied health students may consist of phlebotomy/laboratory paramedic students.

C. The Division of Public Health Services and the school of nursing will maintain a current contract with the roles and responsibilities of each agency listed.

D. It is recommended that 2 originals be sent from the school so that the Division of Public Health Services, the Rockingham County Finance/ Legal Department and the school each have an original.

E. The contracts are reviewed by the Division of Public Health Services and signed accordingly then forwarded to the Finance Officer/Legal Department for review and signed.

F. Students should not begin their clinical rotation until the Division of Public Health Services and school have both signed the contract.

G. Students must complete the agency's Non-Employment Applicants Policy documentation. This documentation must be received, forwarded and approved by Human Resource (HR) office prior to students beginning their preceptorship.

H. Nurse Practitioner students must provide a current copy of the information listed above in Paragraph G.

Copies will be maintained in the Division of Public Health Services' Human Resource office and County HR as above.

I. Schools will be offered a general orientation to the health department and its services as well as a more specific orientation in the area in which the students will be assigned. Students will be welcomed and provided the most comprehensive experience, within their scope, that is possible given the agency's ability to meet the written goals and objectives of the school.

J. The health department staff will attempt to offer as many experiences as possible that will meet goals and objectives of the students.

1. Assignments of personnel will be made according to the specialty mentioned in the goals and objectives of the student.

2. Personnel will be supplied a copy of goals and objectives from the school.

3. The student's experience will be discussed between the student, staff member and the supervisor to determine if goals and objectives were met.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MINORS' CONSENT

DATE DEVELOPED: 1/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16

I. POLICY:

The Division of Public Health Services will adhere to minors consent for treatment as outlined in this policy.

II. PURPOSE:

To identify general statutes and rules that govern the health care provided to a minor.

III. GUIDELINES:

A. Terms and Definitions:

1. Parent - a child's biological or adoptive parent.
2. Guardian - someone appointed by a court to have the care, custody, and control of the child, or to arrange for an appropriate placement for the child.
3. Custodian - a person or agency with legal custody of a child.
4. Caretaker - someone other than a parent, guardian, or custodian who is responsible for a child's health and welfare in a residential setting. This term includes:

    a. stepparent
    b. foster parent
    c. adult member of a child's household
    d. an adult relative who has been entrusted with the child's care, people who supervise children in residential child care facilities or schools
    e. people who care for children in a child day care home or facility
5. Emancipated minor – a minor who is married or who has been granted an order of emancipation by a court – G.S. 7B – 3500 et.seq.
6. *loco parentis* – someone acting in place of the parents.

B. Consent for Treatment:

1. General rule of parental consent:

- In most cases a child under the age of 18 may not receive medical treatment without the consent of the child's parent, legal guardian, or a person acting in *loco parentis* (in the place of a parent). G.S. 7B-3400 (juvenile under 18 years of age shall be subject to supervision and control of juvenile's parents).

2. Exceptions to the above rule:

a. A parent or legal guardian may authorize another person to consent to the minor's care during a period in which the parent or guardian is unavailable – G.S. 32A – 28 et. seq.

b. G.S. 90-21.1
Authorizes physicians to treat a minor without the consent of the parent, legal guardian, or person acting in *loco parentis* under the following emergencies:

- The parent or other authorized person cannot be located or contacted with reasonable diligence during the time within which the minor needs the treatment
- The minor's identity is unknown
- The need for immediate treatment is so apparent that any effort to secure approval would delay the treatment so long as to endanger the minor's life
- An effort to contact the parent or other authorized person would result in a delay that would seriously worsen the minor's physical condition
- The parent refuses to consent, and the need for immediate treatment is so apparent that the delay required to obtain a court order would endanger the minor's life or seriously worsen the minor's physical condition, and two licensed physicians agree that the treatment is necessary to prevent immediate harm to the minor.
- Provided, however, that the refusal of a physician to use, perform or render treatment to a minor without the consent of the minor's parent, guardian, or person standing in the position of *loco parentis*, in accordance with this Article, shall not constitute grounds for a civil action or criminal proceedings against such physician. (1965, c. 810, s. 1; 1977, c. 625, s. 1.)

3. Special rule for Immunizations:

   a. A physician or local health department may immunize a minor who is presented for immunization by an adult who signs a statement that he or she has been authorized by the parent, guardian, or person standing in *loco parentis* to obtain the immunization for the minor. G.S. 130A-153(d).

   b. North Carolina Law permits a local health department to immunize a child in the following circumstances:

      - when the child's parent, guardian, or person standing in *loco parentis* presents the child for the immunization and gives consent for the immunization, or
      - when another adult presents the child for immunization and signs a statement that he or she is authorized by a parent, guardian, or person standing in *loco parentis* to obtain the immunization (G.S. 130A-153(d)), or
      - per the Minors' Consent Law (G.S.90-21.5), a minor may consent to his/her own immunizations only if they are mature enough to make their own decisions. Varicella is not a reportable CD in North Carolina so no varicella can be given without parental consent.

   c. The Division of Public Health Services will utilize the Immunization consent to obtain permission through a signed consent for treatment.

4. A minor may consent to the following:

   1. An emancipated minor may consent to his or her own treatment.
   2. Minors' Consent Rule (G.S. 90-21.5(a)):

      A minor may give effective consent for his or her own treatment for the prevention, diagnosis, or treatment of the following conditions:

      - reportable communicable disease
      - pregnancy
      - abuse of controlled substance or alcohol
      - emotional disturbance

Exceptions: The minor may not consent to sterilization, abortion, or admission to a 24-hour mental health or substance facility (except that the minor may consent to admission to such a facility in an emergency).

a. Family Planning Services shall be available to all who voluntarily request such services without regard to age or parental consent. 10A NCAC 43A .503
b. Method-specific informed consent shall be obtained each time the individual changes the birth control method selected. 10A NCAC 43A .504

C. Confidentiality of Minors' Treatment Information:

1. G.S. 90-21. 4(b): Information about treatment that was provided to a minor upon his/her own consent pursuant to G.S. 90-21.5 should not be released to the minor's parent or legal guardian except in the following two circumstances:

   If release of the information is essential to protect the life or health of the minor, the physician <u>should</u> release the information.

2. Notice of Privacy Practices:

   a. If it is the first delivery of service to the child since April 14, 2003, the Division of Public Health Services must provide the Notice of Privacy Practices to the child's parent, guardian, or person standing in *loco parentis*.

      The health department must also make a good faith effort to obtain acknowledgement of receipt of the Notice of Privacy Practices from the parent, guardian, or person standing in *loco parentis*.

   b. The Division will give the Notice of Privacy Practice and the form acknowledging receipt of The Privacy Practice to the adult who presents the child for services.
   c. The Division should instruct the adult to deliver both items to the child's parent, guardian, or person standing in *loco parentis* with the request that the parent, guardian or person standing in *loco parentis* sign it and return it to the health department
   d. The Division could also mail the Privacy Practice and the form acknowledging receipt of the Notice of Privacy Practice to the child's parent, guardian, or person standing in *loco parentis.*

e. The Division must document its good faith effort to obtain the acknowledgement.

f. An adult other than a parent, guardian, or person standing in loco parentis who presents a child for immunization is not a personal representative of the child for purposes of the HIPAA privacy rule, and therefore cannot acknowledge receipt of The Notice of Privacy Practice on the child's behalf.

g. It is the policy of the Division of Public Health Services to be presumed that the reason the acknowledgement was not obtained was that the parent, guardian, or person standing in *loco parentis* failed to return the form. A notation of "PROTOCOLS WERE FOLLOWED" will suffice to document this presumptive reason.

h. If the parent, guardian, or person standing in *loco parentis* objects or refuses to sign The Notice of Privacy Practice, this should be documented.

3. a. The Division of Public Health Services may ask the adult that presents the child to sign a form giving consent to use or disclose information when the form is strictly limited to provide:

- The only information that may be disclosed is information related to the immunization the adult signed for, and
- The only purposes for which the information may be used or disclosed are treatment, payment, and health care operations.

b. The adult (other than parent, guardian, or person standing in *loco parentis*) must not sign a form giving consent to use or disclose any other of the child's health information for any purpose.

c. Notice of Privacy Practice information to be used or disclosed must be signed, as approved to use or disclose, by the parent, guardian, or person standing in *loco parentis*.

D. Delegation of Power to make Health Care Decisions for a Minor Child:

1. In the event the Authorization to Consent to Health Care for Minor form is not attainable, the Division of Public Health Services' nursing staff may contact the parent, guardian, or person standing in *loco parentis* by phone to acquire verbal consent of treatment for the minor.

2. Any custodial parent who is at least 18 years old and who is capable of making and communicating health care decisions may authorize someone else to make health care decisions for a minor child.

3. Parents who are less than 18 years old must ask a court to declare them legally an adult before they may delegate this power. (A custodial parent is a parent having sole or joint legal custody of his or her minor child.)

E. When is the agent's power ended?

1. The parent may give the agent broad powers to consent to health care for the minor child. Or, the parent may limit the agent's power.

2. The custodial parent who authorized the agent to make health care decisions for a minor may revoke the power at any time. The revocation is effective when the parent informs the agent that his or her power is revoked.

   a. The agent's power is revoked automatically in the following situations.
   b. If the "Authorization to Consent to Health Care for Minor" sets an expiration date, it is revoked on that date.
   c. It is revoked when the minor reaches 18 years of age, or if a court declares the minor legally an adult.
   d. It is revoked if the parent who granted the power loses custody of the minor.
   e. If either parent or the agent disagrees over the health care decisions for the minor, it is revoked during the period of disagreement.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: **EVALUATION AND TREATMENT OF PEDICULOSIS CAPITIS (HEAD LICE) IN CHILDREN AND ADULTS**

DATE DEVELOPED: **1/02**
REVIEWED: **6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/16; 6/17**

I. POLICY:

The Division of Public Health Services will provide evaluation and treatment for head lice in children and adult clients presenting for this service and meeting financial eligibility guidelines.

II. PURPOSE:

The Division of Public Health Services shall provide assessment, diagnosis, and client education in the treatment and prevention of Pediculosis Capitis (head lice) infestation.

III. GUIDELINES:

A. Eligibility for this service requires that the client meet the following criteria:

The financial responsibility for this appointment and any prescription cost is solely that of the parent/legal guardian. These costs may be billable to Health Check, Health Choice, or private insurance, if the child is covered by any of these pay sources. Should care be provided by the Division of Public Health Services, payment for services is based on a sliding scale pending verified household income.

1. Clients will be treated who present at the clinic and have evidence of Pediculosis Capitis infestation that is confirmed by a Public Health Nurse or Advanced Practice Provider (APP):

    a. Visualized lice; and/or
    b. Nits

2. One annual treatment is provided to individuals who present with a verified infestation.

    a. The nurse or APP verifying infestation shall encourage the client to bring in close contacts and/or household family members for evaluation and treatment of potential infestation.

b. The Division of Public Health Services does not treat any family members unless they are screened. They must present into the health department.

B. Evaluation and Diagnosis:

1. The nurse or APP shall don gloves and utilize a tongue depressor, if necessary, to section hair for easier visualization of lice and/or nits.

2. The nurse or APP shall initiate the examination at the nape of the neck and inspect along the hairline to the posterior auricular region of the scalp inspecting the hair and scalp for lice and/or nits.
   - Retail outlets and pharmacies also carry special combs used to facilitate the removal of nits; our agency only offers the comb that is included in the annual courtesy treatment mentioned above.
   - Apple cider vinegar applied to the hair and allowed to saturate for 30 to 60 minutes in a towel wrap has been found to be somewhat effective in loosening the substance, attaching nits to strands of hair.
   - Most schools do not allow students to return to classes if nits are found in the hair, even after verified treatment with an anti-louse product and (most likely) the nits are dead.
     - Follow school policy for readmission.
   - Head lice can only live on humans, and cannot be transmitted from pet to an individual or vice versus.

C. Client Education or Teaching:

Once an infestation is verified, and the client meets the required criteria noted in III. A. 1. of this policy, the client must be educated on the correct procedure to permanently treat and prevent pediculosis capitis reinfestation.

1. Pediculosis capitis is spread by close personal contact with another individual infested with head lice by:
   - Sharing or using combs, brushes and other grooming aids.
   - Wearing an infested person's hat, cap, wig, coat, or scarf.
   - Close contact with an individual's bedding or clothing.

2. The nurse or APP must stress to the client/ client's parent the importance of compliance with all instructions to decontaminate and prevent reinfestation of pediculosis capitis:
   - Heat will kill lice and their nits. All bed linens, clothing,

personal items worn or used over the past three days can be disinfected by machine washing in hot water (51.5°C or 125°F or higher), and/or machine drying using the high heat setting for at least 20 minutes.

- Clothing and bedding that cannot be machine washed or dried can be dry cleaned or left in a plastic bag and sealed for a period of 14 days.
- Combs, brushes, and similar items can be disinfected by soaking them in hot water ((51.5°C or 125°F or higher) for 30 minutes.
- Vacuuming the individual's home environment (bedding, upholstery, stuffed animals, carpeting, car interior, etc.) then discarding the bag or contents of the bag less vacuuming system, by sealing it in a plastic bag and removing it from the home.

    - If using a bag less vacuuming system, wash the container in hot water at the temperatures noted above, and allow the container to dry well prior to reinstallation in the bag-less vacuuming system

3. If more than one family member has been verified as infested, instruct the client to treat everyone at the same time, as well as cleaning personal belongings and the environment at the same time.

D. Treatment:

1. The infested individual's clothing should be removed and sealed in a plastic bag until it can be washed following the instructions listed above.

2. The client must follow directions on the product label exactly as listed to assure that treatment is effective.

    a. If the product instructions require the product be applied and left on the hair for a set period of time, instruct the client to start timing once the treatment is completely applied, and to use a mechanical timer (kitchen timer, for example).
    b. Instruct the client not to leave the product on the hair for longer than the recommended time.
    c. The client should rinse the product out of the hair until the water runs clear.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ABBREVIATIONS

DATE DEVELOPED: 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services' staff members use acceptable abbreviations in documenting client clinical records.

II. PURPOSE:

To standardize terminology used in client clinical records.

III. GUIDELINES:

The Division of Public Health Services will use the attached list of abbreviations when documenting in client records.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Approved Abbreviation List

A

A-R	apical-radial pulse
A/G	albumin/globulin
ACTH	corticotropin, adrenocorticotropic hormone
ADA	"diabetic" diet
ADH	antidiuretic hormone
ADL	activities of daily living
AEB	as evidenced by
AFB	acid fast bacilli
AFP	alpha feto protein
AGA	average for gestational age
AH	adult health
AHR-RRR	apical heart rate - regular rate & rhythm
AIDS	acquired immune deficiency syndrome
AKA	above knee amputation
ALS	amyotrophic lateral sclerosis
AM	**morning**
AMA	against medical advice
AP	apical pulse/anteroposterior
APC	**Adult Primary Care**
APH	Annie Penn Hospital
ASA	**aspirin**
ASAP	as soon as possible
ASCUS, ASC-us	atypical squamous cells of undetermined significance
ASCVD	arteriosclerotic cardiovascular disease
ASD	atrial septal defect
ASHD	arteriosclerotic heart disease
ASQ	Ages and Stages Questionnaire
AV	atrioventricular
Ab	abortion
Abd	abdomen/**abdominal**
Amnio	amniocentesis

Amt	amount
a.c.	before meals
a.c.h.s.	**before meals and at bedtime**
ad	right ear
ad lib	as desired
approp	appropriate
approx	approximate
appt.	appointment
apt	apartment
as	left ear
au	both ears

B

B	black
BBB	bundle branch block
BBT	basal body temperature
BC	birth control
BCM	**birth control method**
BCP	birth control pill
BF	black female
BGSM	Bowman Gray School of Medicine
BKA	below the knee amputation
BM	bowel movement
BMI	body mass index
BMR	basal metabolic rate
BP or B/P	blood pressure
BR	bed rest
BS	blood sugar
BSO	bilateral salpingo-oophorectomy
BSx4	bowel sounds times four
BTL	bilateral tubal ligation
BUN	blood urea nitrogen
BV	bacterial vaginosis
BW	birth weight
Bx	biopsy
bid	twice a day
bil	bilateral

C

c̄	with
C&S	culture and sensitivity
c/o	complaint of
C/S or C-section	cesarean section
CA, Ca	cancer
CABG	coronary artery by-pass graft
cal.	calories
CAP-DA	Community Alternative Program-Disabled Adults
CBC	complete blood count
CBE	clinical breast exam
CC or C.C.	chief complaint
CCNC	community care of North Carolina
CCU	clean catch urine
CDSA	Children's Developmental Services Agency
CF	Cystic Fibrosis
CHA	comprehensive health assessment
CHD	congenital heart disease
CHF	congestive heart failure
CIN	cervical intraepithelial neoplasia
CIS	carcinoma in situ
ck	check
cm	centimeter
CMARC	Care Management for At Risk Children
CMC	Children's Medical Center
CMHRP	Care Management for High Risk Pregnancies
CMIS	case management information system
CMP	**comprehensive metabolic panel**
CMV	cytomegalovirus
CNS	central nervous system
co	counseling
COA	Council on Aging
COC	**combination oral contraception**
Colpo	colposcopy
cond.	condition
Cont. or cont	continued
COPD	chronic obstructive pulmonary disease

CP	**chest pain**
cpd	cigarettes per day
CPE	complete physical exam
CPK	creatine phosphokinase
CPS	Child Protective Services
CRF	chronic renal failure
cryo	cryosurgery
CSF	cerebrospinal fluid
CT	**Chlamydia Trachomatis; Computerized Tomography**
CTA AP& Lat	clear to ascultation anterior posterior and laterally
CV	cardiovascular
CVA	**cardiovascular accident; cerebrovascular accident; costovertebral angle**
CVD	cardiovascular disease
cx	**cervix or culture**
CXR	**chest x-ray**

D

d	day
D & C	dilatation and curettage
d/t	due to
DC or D/C	discontinue; discharge
Depo or depo	Depo Provera
DES	diethylstilbestrol
DM	diabetes mellitus
DNA	deoxyribonucleic acid
DNKA	did not keep appointment
DOA	dead on arrival
DOB	date of birth
DOE	**dyspnea on exertion**
DPT	diptheria-pertusis-tetanus
DSS	Department of Social Services
DT	diphtheria-tetanus
DT's	delirium tremors
DTaP	Diptheria-Tetanus-acellular Pertusis
DTR's	deep tendon reflexes
DUMC	Duke University Medical Center
DV	dental varnish

Dx	diagnosis

E

EAB	**elective abortion**
ECC	endocervical curettage
ECG, EKG	electrocardiogram
ECHO or echo	echocardiogram
EDC	expected date of confinement
EEG	electroencephalogram
EENT, ENT	eyes, ears, nose, and throat
EGA	estimated gestational age
EMB	ethambutol
EOM	extraocular movement, extraocular muscles
ER or ED	emergency room
ESC	Employment Security Commission
ESR	erythrocyte sedimentation rate
ESRD	end stage renal disease
ETOH	alcohol
Exc.	excision
Expl.	exploratory

F

F	Fahrenheit
F, C, VCF	foam, condoms, vaginal contraceptive foam
F/U	follow-up
Fa	father
FBS	fasting blood sugar
FeSO4	ferrous sulfate
FH	fundal height
FHR	fetal heart rate
FHT	fetal heart tone
FM	fetal movement
FNP	Family Nurse Practitioner
FOB	father of baby
FOC	father of child
FP	family planning
FPPE	family planning physical exam

FSH	follicle stimulating hormone
FUO	fever of unknown origin
Fx	fracture

G

G	gravida
G.I. or GI	gastrointestinal
G.T.T.	glucose tolerance test
GB	gall bladder
GC	gonorrhea
GED	General Education Degree
GFR	**glomerular filtration rate**
gm	gram
gr	grain
gtts	drops
GU	genitourinary
GYN	gynecology

H

H	Hispanic
h, hr, hrs	hour, hours
h.s.	**at bedtime**
H2O	water
HA	headache
HBP, HTN	hypertension
HBV	Hepatitis B Virus
HC	head circumference
HCG	human chorionic gonadotrophin
HCT or Hct	hematocrit
HCV	Hepatitis C Virus
HEENT	head, eyes, ears, nose and throat
HGB or Hgb	hemoglobin
Hgb. Elect	hemoglobin electrophoresis
HGSIL	high-grade squamous intraepithelial lesion
HHA	Home Health Agency
HIB	Haemophilus Influenzae B
HIE	**health information exchange**
HIV	human immunodeficiency virus

HMG	human menopausal gonadotropin
HOH	hard of hearing
hosp.	hospital
HPI	history of present illness
HPV	human papillomavirus
HR	**heart rate**
HRC	High Risk Clinic
HS	high school
HS grad	high school graduate
HSG	hysterosalpingogram
HSIL	**high-grade intraepithelial lesion**
HSV-I	Herpes Simplex Virus I
HSV-II	Herpes Simplex Virus II
ht.	height
HV	home visit
Hx or H/O	history; history of
hyst.	Hysterectomy

I

I & D	incision and drainage
I&O	intake and output
I&R	identification and referral (CSC Program)
ICU	intensive care unit
IDDM	insulin dependent diabetes mellitus
IgA	immunoglobulin A (could be E, G, M, etc.)
IM or I.M.	intramuscular
info	information
INH	isoniazid
IPV	inactivated polio vaccine
IQ	intelligence quotient
ITP	idiopathic thrombocytopenic purpura
IUD	intrauterine device
IUP	intrauterine pregnancy
IV	intravenous(ly)
IVP	intravenous pyelogram

J

JRTC	Job Resource Training Center

K

KBR	Kate B. Reynolds
kg	kilogram
KHA	Kindergarten Health Assessment
km	kilometer
KUB	kidney, ureter, bladder

L

(L) or lt.	left
L & D	labor and delivery
L/S ratio	Lecithin/sphingomyelin ratio
LA	left arm
LAP	**laparoscopy**
lb or lb.	pound
LBW	low birthweight
LD	left deltoid
LE	**lower extremity**
LEEP	loop electrosurgical excision procedure
Lg or lg.	large
LGA	large for gestational age
LGSIL	**low-grade squamous intraepithelial lesion**
LGV	lymphogranuloma venereum
LH	luteinizing hormone
liq.	liquid
LLE	left lower extremity
LLIQ	**left lower inner quadrant**
LLL	left lower lobe
LLOQ	**left lower outer quadrant**
LLQ	left lower quadrant
LMP	last menstrual period
LNMP	last normal menstrual period
LOA	leave of absence
LP	lumbar puncture

LPC	late prenatal care
LPN	licensed practical nurse
LSB	left sternal border
LSIL	low-grade intraepithelial lesion
LSP	life skills progression
LUE	left upper extremity
LUIQ	**left upper inner quadrant**
LUL	left upper lobe
LUOQ	**left upper outer quadrant**
LUQ	left upper quadrant
LV	left ventricle

M

m	murmur
Ma	maternal aunt
MAE	moves all extremities
MCH	mean corpuscular hemoglobin
MCHC	mean corpuscular hemoglobin concentration or count
MCMH	Moses Cone Memorial Hospital
MCV	mean corpuscular volume
MD	medical doctor
mEq.	milliequivalent
met. or met	metastasis, metastatic
mg.	milligram
MGF	maternal grandfather
MGM	maternal grandmother
Mgt	management
MH	mobile home
MHC	mental health center
MI	myocardial infarction
micro	micro urinalysis
min.	minute
ml	milliliter
mm	millimeter
MMH	Morehead Memorial Hospital
mo	mother
mo(s) or mo.	month(s)
MOA	medical office assistant

MOB	mother of baby
MOM	milk of magnesia
MPC	mucopurulent cervicitis
mph	miles per hour
MPW	Medicaid for Pregnant Women
MRSA	Methicillin Resistant Staphylococcal Aureus
MS	multiple sclerosis
MSE	mental status examination
msg. or msg	message
MSW	medical social worker
Mu	maternal uncle
multip.	multiple pregnancy
MVA	motor vehicle accident

N

N & V	nausea and vomiting
N/A	not applicable
N/S	normal size
NB	newborn
NCP	nursing care plan
neg or N	negative
NGU	nongonococcal urethritis
NIDDM	non-insulin dependent diabetes mellitus
NKA	no known allergy
NKDA	no known drug allergy
NP	Nurse Practitioner
NPC	no prenatal care
NPH insulin	neutral protamine Hagedorn insulin
NPO	nothing by mouth
NSR	normal sinus rhythm
NSS	normal saline solution
NSSC	**normal size, shape, contour**
NSVD	normal spontaneous vaginal delivery
NT	**non-tender**
NTND	**non-tender, non-distended**

O

O2, O2 sat.	oxygen, oxygen saturation
OB	obstetrics
OB/GYN	obstetrics/gynecology
OBS	organic brain syndrome
OC's	oral contraceptives
OCP	**oral contraceptive pill**
OD	right eye, optical density
OOB	out of bed
ORIF	open reduction internal fixation
OS	left eye
OSHA	**Occupational Safety and Health Administration**
OT	occupational therapy, objective test, otology, old tuberculin
OTC	**over the counter**
OU	both eyes
oz.	ounce

P

$\overline{p}$	after
P	para
P	pulse
P2	pulmonic, second sound
P4HM	partnership for health management
Pa	paternal aunt
PA	Physician Assistant
PA-C	**Physician Assistant certified**
PAT	parents as teachers
pc	after meals
PCN	Penicillin
PDR	Physician's Desk Reference
PE	Presumptive Eligibility
PERRLA	pupil equal, regular reactive to light and accommodation
PFSH	past family and social history
PGM, PGF	paternal grandmother, grandfather
pH	hydrogen ion concentration; acidity value of blood or urine
PHN	Public Health Nurse
PID	pelvic inflammatory disease

PIH	pregnancy induced hypertension
pkg	package
PKU	phenylketonuria
PMB	postmenopausal bleeding
PMH	**past medical history; pregnancy medical home**
PMI	point of maximum impulse (heart)
PMPM	per member per month
PMS	premenstrual syndrome
PNV	prenatal vitamin
po	oral, orally
POP	**progestin only pill**
pos	positive
PP	post partum
ppd	pack per day
Preg.	pregnant, pregnancy
primip.	1st pregnancy
PRN	whenever necessary
PROM	premature rupture of membranes
Protime	prothrombin time
PT	physical therapy
Pt.	patient
Pu	paternal uncle
PUP	pruritic urticarial papules
PVC	premature ventricular contraction
PZA	pyrazinamide

Q

$\overline{q}$	every
q2h	every 2 hours
qd	**every day**
qh	every hour
qhs	every bedtime
qid	four times a day
qod	**every other day**
QRS	ventricular complex (as shown in electrocardiogram)
qt.	quart

R

Ⓡ or rt.	Right
r/o	rule out
R/T	related to
RA	right arm
RBBB	right bundle branch block
RBC	red blood cells, red blood cell count
RCC	Rockingham Community College
RCDPH	Rockingham County Department of Public Health
RDS	respiratory distress syndrome
re:	regarding
resp.	respirations, respiratory
RHD	rheumatic heart disease
RHS	Routine Health Supervision
RIF	rifampin
RLE	right lower extremity
RLIQ	**right lower inner quadrant**
RLL	right lower lobe
RLOQ	**right lower outer quadrant**
RLQ	right lower quadrant
RML	right middle lobe
RN	Registered Nurse
RNA	ribonucleic acid
ROI	Release of Information
ROM	range of motion
ROS	review of systems
RR	Red Reflex
RTC	return to clinic
RTW	return to work
RUE	right upper extremity
RUIQ	**right upper inner quadrant**
RUL	right upper lobe
RUOQ	**right upper outer quadrant**
RUQ	right upper quadrant
RV	right ventricle
Rx	prescription

S

S&N	strength and needs
S.S.N.	social security number
S/P	status post
S/S	signs & symptoms
SA node	sinoatrial node
SAb	spontaneous abortion
SBE	self breast exam
SC	sickle cell
SCJ	squamocolumnar junction
SGA	small for gestational age
SIDS	Sudden Infant Death Syndrome
SLE	systemic lupus erythematosus
sm	small
SN	skilled nursing
SOAP	subjective, objective, assessment, plan
SOB	shortness of breath
spec.	specimen
SROM	spontaneous rupture of membranes
SSI	Supplemental Security Income
ST	speech therapy
STAT	immediately
STD or STI	sexually transmitted disease, sexually transmitted infection
supp.	suppository
SVT	supraventricular tachycardia
Sx	**symptoms**

T

T3	tri-iodothyronine
T4	tetraiodothyronine, L-thyroxine
Tab	tablet
TAB	therapeutic abortion
TAH	total abdominal hysterectomy
TB	tuberculosis
TBC	thyroxine-binding coagulation
TC	telephone call
Td	Tetanus-diphtheria

Temp	temperature
TIBC	total iron-binding capacity
tid	three times a day
TPN	total parenteral nutrition
TPR	temperature, pulse, respiration
Trich.	trichomoniasis
TRUST	test for syphilis
TSH	thyroid-stimulating hormone
TST	Tuberculin Skin Test
TTP	**tender to palpation**
TV	tidal volume
TVUS	**transvaginal ultrasound**
Tx	**treatment**

U

UA or U/A	urinalysis
UNCR	**UNC Rockingham Health Care**
UPT	**urine pregnancy test**
URI	upper respiratory infection
US	ultra sound
UTD	Up To Date
UTI	urinary tract infection

V

vag.	vaginal
vag. hyst.	vaginal hysterectomy
VAMC	Veterans Administration Medical Center
VBAC	vaginal birth after c-section
vit.	vitamin
vm	voice mail
vol.	volume
VS	vital signs
VSD	ventricular septal defect
VSS	vital signs stable
VU	verbalized understanding

W

W	white
w/	**with**
w/o	**without**
WBC	white blood cells, white blood cell count, white blood corpuscles
WF	white female
WFFA	Work First Family Assistance
WFU/BMC	Wake Forest University Baptist Medical Center
WHC	Women's Health Center
WHOG	Women's Hospital of Greensboro
WIC	Women, Infant, Children
wk.	week
WLCH	Wesley Long Community Hospital
WNA	Was Not Addressed
WNL or wnl	within normal limits
wt.	weight

Y

yd	yard
yo or y/o	years old
yr.	year

Symbols

↓	decreased or down
↑	increased or up
=	equal
≠	unequal
♂	male
♀	female

$\overline{c}$	with
$\overline{s}$	without
+	plus, positive
-	minus, negative
'	foot or feet (measurement)
"	inches
º	degrees
↓↓	descended (testicles) or flexor (plantar responses)
~	approximately
x	times
Δ	change
1º	primary
2º	secondary
$\overline{x}$	except
	right
	left
Ø	none, nothing
#	pound or number

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PRIVACY PROTOCOLS FOR THE CLINIC

DATE DEVELOPED: 3/06
REVIEWED: 6/16; 6/17; 10/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 10/17

I. POLICY:

The Division of Public Health Services will strive to maintain privacy for our clinic services.

II. PURPOSE:

To ensure that the client's privacy is implemented while the client is receiving clinical services.

III. GUIDELINES:

A. The Division of Public Health Services follows its agency HIPAA policies in maintaining client confidentiality. (Please refer to the Division of Public Health Services' Health Insurance Portability and Accountability Act of 1996 – Manual.)

B. The privacy of the clinical area will be maintained in the following manner:

1. Electronic card readers have been placed at clinic entrances that can only be accessed by county identification badges.

2. When clients are escorted behind the clinic hall doors, no other person will be allowed to accompany them unless there is an extenuating circumstance such as:

   a. The person is the mother, father, guardian, or individual standing in *loco parentis* for the minor.
   b. The client has difficulty with ambulation, memory loss, physical handicap, or inability to function independently.
   c. The person holding power of attorney status for the client.
   d. The client signs a "Second Party Consent" form.

3. No cell phones are allowed for use within the clinical area. Sound recording, videotaping, and photographs by patients, family members or other individuals during patient interviews, examinations, or procedures is not permitted without expressed consent of staff, providers, and patients.

4. Clients are escorted through the clinical area by a staff member.

5. Staff are instructed to stop anyone that comes into the clinical area unattended by a staff member.

6. Staff are not allowed to release information to anyone inquiring about a client or client status.

7. Staff are not permitted to release any kind of information that would imply the person in question is currently receiving clinical services or within the health care facility.

8. Clients are placed in a clinical room as soon as possible. Exam tables are positioned to provide maximum protection of privacy for the client.

9. The door should remain closed at all times while the client is in the room. Staff should knock before entering and wait for a response before entering to ensure privacy is maintained. When preparing to enter a clinic room staff will be aware of other client and staff movement on the clinic hall to assure client privacy. Screens are provided in rooms to further protect client privacy.

10. Do not allow clients to stand in the doorway or leave the clinic room unattended.

11. Staff should not be discussing client's names or medical conditions in the hallways.

12. When following up with a triage phone call, close the door so passer-byers cannot hear the conversation.

13. Do not leave client clinical records unattended in the clinic rooms, hallways or office. Maintain privacy as per instructed through HIPAA agency policies.

C. All staff of the Division of Public Health Services will sign an agency confidentiality form upon hire and annually at the time of their annual performance evaluation. All staff of the Division of Public Health Services will sign an agency computer use form upon hire and annually thereafter at the time of their performance evaluation. Any employee who does not follow confidentiality/computer use policies is subject to disciplinary action up to possible termination.

D. The Division of Public Health Services will follow Rockingham County Governmental IT Policy regarding usage.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: INFLUENZA SEASON

DATE DEVELOPED: 9/13/99
REVIEWED: 8/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 8/15; 6/23

I. POLICY:

The Division of Public Health Services will provide influenza vaccines to clients in the clinical setting and at the off-site community outreach clinics as scheduled.

II. PURPOSE:

To reduce the number of deaths and the burden of illness caused by influenza related disease and to increase immunization levels for the influenza vaccinations among those at risk.

III. GUIDELINES:

The Division of Public Health Services will manage the influenza vaccine for the current influenza season according to the Center's for Disease Control and Prevention (CDC) and the North Carolina Division of Public Health's suggestions.

A. The main way influenza is spread is from person to person in respiratory droplets of coughs and sneezes.

B. This spread can happen when droplets from a cough or a sneeze of an infected person are propelled (generally up to 3 feet) through the air and deposited on the mouth or nose of people nearby.

C. Viruses can also be spread when a person touches the respiratory droplets from a person or object and then touches their nose or mouth before washing their hands.

D. 1. The typical incubation period for influenza is 1-4 days, with an average of 2 days.

2. Adults can be infectious from the day before symptoms begin through approximately 5 days after illness onset.

3. Children can be infectious for $\geq$ 10 days after the onset of symptoms and young children also can shed virus before their illness onset.

E. If a diagnosis of flu, the patient should:

- Rest
- Drink plenty of liquids
- Avoid using alcohol and tobacco
- Take medications to relieve the symptoms of flu.

F. DO NOT give aspirin to a child or teenager who has the flu.

G. When vaccine supply is limited vaccination efforts should focus on the following groups:

1. Children aged 6 months to 4 years;
2. Household contacts and caregivers of children aged <5 years and adults aged ≥50 years with emphasis on vaccinating contacts of children aged <6 months;
3. Children and adolescents (aged 6 months – 18 years) who are receiving long-term aspirin therapy and, therefore, might be at risk for experiencing Reye syndrome after influenza virus infection;
4. Women who will be pregnant during the influenza season;
5. Adults and children who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological or metabolic disorders (including diabetes mellitus);
6. Adults and children who have immunosuppression (including immunosuppression caused by medications or by HIV);
7. Adults and children who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration;
8. Residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions;
9. Persons aged ≥ 50 years of age;
10. Persons who are American Indian/Alaska Native;
11. Persons who are morbidly obese;
12. Health care personnel.

H. The influenza vaccine is also recommended for all persons aged ≥6 months who do not have contraindications to the vaccine.

I. Individuals who should not get the flu vaccine:

1. People who have ever had a severe allergic reaction to eggs or egg products or to a previous flu shot.

2. People who have a history of Guillain-Barre' Syndrome (fever, nerve damage, muscle weakness) after receiving flu shot.

3. Fever at the time of request for vaccination.

J. Risks from getting flu vaccine:

1. The viruses in the flu vaccine are inactivated (killed).

2. The risk of the flu vaccine causing serious harm or death is extremely small.

3. Any vaccine may rarely cause a severe allergic reaction, especially in people allergic to eggs. The viruses are grown in chicken eggs. Signs of serious allergic reaction can include breathing problems, hoarseness, wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness.

K. Side effects of flu vaccine:

1. Soreness, redness, or swelling at the site

2. Fever (low grade)

3. Aches.

If side effects occur, they may last from 1-2 days. Notify MD if reactions occur. The Division of Public Health Services staff needs to be notified of all severe reactions from the vaccine administration. A Vaccine Adverse Event Reporting System (VAERS) form is completed or call 1-800-822-7967.

L. Administration of the Influenza Vaccine:

1. The best time to the get influenza vaccine is October through November. Vaccine will continue to be provided as long as vaccine is available.

2. A new vaccine is needed each year.

a. People 9 years of age or older need one vaccine.

b. Vaccination of children aged 6 months to 8 years who are receiving the vaccine for the first time should receive 2 doses

of vaccine if they have not been vaccinated previously with either LAIV or TIV (doses separated by ≥ 4 weeks).

c. Children aged 6 months to 8 years who received only one dose in their first year of vaccination receive 2 doses the following year with single annual doses in subsequent years.

d. LAIV should not be administered to children ≤ 5 with possible reactive airway disease such as wheezing episode or asthma.

e. Children aged 6 to 23 months and persons ≥ 49 years should receive IIV.

3. Inactivated influenza vaccine can be given at the same time as other vaccines.

4. Dosage recommendations vary according to age group.

5. Thimersol, a mercury-containing compound, has been used as a preservative in vaccines and is used in multi-dose vials of inactivated influenza to reduce the likelihood of bacterial contamination. No scientific evidence indicates that thimersol in vaccines leads to serious adverse events.

6. The influenza vaccine is given to clients that request it and the Division of Public Health Services' licensed staff are covered to provide this administration of the vaccines through approved annually updated standing orders that have been reviewed and signed by the medial director. Policies and standing orders are then reviewed by the staff for compliance.

7. Pregnant Women

- All pregnant women during the influenza season will be offered an influenza vaccine with documentation of date vaccine was given or refused included in the client's chart. Women with medical conditions that increase their risk of complications from influenza shall be offered the vaccine during the influenza season regardless of the stage of pregnancy.
- CDC recommends pregnant women receive only inactivated influenza vaccine.
- The Division of Public Health Services may administer state supplied influenza vaccine to any non-Medicaid recipient who will be pregnant during the flu season regardless of age and is being served by the health department in any capacity. Medicaid enrolled prenatal clients greater than 18 years of age must receive privately purchased influenza vaccine if they wish to receive influenza vaccine.

M. Recommendations for using antiviral agents for Influenza

1. Antiviral drugs for influenza are an adjunct to influenza vaccine for controlling and preventing influenza. However, these agents are not a substitute for vaccination. Four licensed influenza antiviral agents are available in the United States: zanamivir, oseltamivir, amantadine, and rimantadine.

2. Private physicians and physician extenders may prescribe medication for clients.

N. Laboratory Diagnosis

1. Appropriate treatment for clients with respiratory illness depends on accurate and timely diagnosis. Early diagnosis of influenza can reduce the inappropriate use of antibiotics and provide the option of using antiviral therapy. However, because certain bacterial infections can produce symptoms similar to influenza, bacterial infections should be considered and appropriately treated, if suspected. In addition, bacterial infections can occur as a complication of influenza.

2. Influenza surveillance information and diagnostic testing can aid clinical judgment and help guide treatment decisions. The accuracy of clinical diagnosis of influenza on the basis of symptoms alone is limited because symptoms from illness caused by other pathogens can overlap considerably with influenza. Influenza surveillance by the health department and CDC can provide information regarding the presence of influenza viruses in the community. Surveillance can also identify the predominant circulating types, subtypes, and strains of influenza.

   Diagnostic tests available for influenza include viral culture, serology, rapid antigen testing, reverse transcriptase-polymerase chain reaction (RT-PCR) and immunoflurescence. Sensitivity and specificity of any test for influenza might vary by the laboratory that performs the test, the type of test used, the type of specimen tested, the quality of the specimen, and the timing of specimen collection in relation to illness onset. Among respiratory specimens for viral isolation or rapid detection, nasopharyngeal and nasal specimens are typically more effective than throat swab specimens. As with any diagnostic test, results should be evaluated in the context of other clinical information available to health care providers.

O. Influenza Surveillance

1. Information regarding influenza surveillance, prevention, detection, and control is available at http://www.cdc.gov/flu/weekly/fluactivity.htm.

2. During October-May surveillance information is updated at least every other week.

3. Updates may be published in the MMWR Weekly @ http://www.cdc.gov/mmwr.

4. The CDC Immunization Hotline can be called @ 1-800-232-4636.

P. Appointments/Walk-Ins/Schedule:

1. Walk-in's are accepted at of-site flu clinics only.

2. Immunizations are administered to Rockingham County Employees depending on availability. *Rockingham County employees are listed as those employees that are covered under the Rockingham County payroll system.*

3. Financial/Payment Policy

   a. Influenza vaccines and administration is filed with contracted insurance carriers.
   b. Medicaid is the payor of last resort.
   c. If a client has Medicare or Medicare HMOs, please indicate on the Influenza/Pneumonia Vaccine Consent Form.
   d. Create and update registration and financial records accurately.
   e. Payments for flu vaccine are expected at time of service for those without insurance. VFC (State supplied) clients should be routed to the correct person to enter the encounter and collect payments.

For Medicare Part B payment information, visit Medicare and Medicaid @ http://www.cms.hhs.gov/medlearn/refimmu.asp. Call the following numbers with billing questions: Medicare – call Palmetto GBA @ 1-888-414-8592. For Medicaid billing call NC Tracks.

4. <u>County Employees</u>

   Rockingham County Employees are provided with the flu vaccine depending on availability. Please enter on the registration record that the individual is a County Employee and *list the department of that employee to verify they are a county employee.* Insurance is filed for county employees.

5. <u>Adult Primary Care/Women's Preventive Health/Pediatric Care</u>

   Clients seen in clinics should be assessed for vaccine needs. <u>No</u> flu vaccines should be given without the proper paperwork.

6. Clients Under Age 18

   Because children (who are being immunized for the first time) receive 2 doses of flu vaccines, this will create two charges for the vaccine.

Q. Forms to Complete for Vaccine Administration –

1. Clients will complete the Influenza/Pneumonia Vaccine Consent Form for the Health Department clinic and community outreach sites or mass clinical site**.**

2. Please document legibly – indicating "∅" to be used for lot number when using the numeric zero.

3. All flu vaccines will be entered into the North Carolina Immunization Registry (NCIR).

4. A chart copy from the NCIR will be available as needed.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: AUTOMATED EXTERNAL DEFIBRILLATOR

DATE DEVELOPED: 12/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17

I. POLICY:

For Heartstream Forerunner AED and Phillips Heartstart FRx + FR2+ AEDs:

The Division of Public Health Services will access the Automated External Defibrillator (AED) in the event of a cardiac emergency.

II. PURPOSE:

The Automated External Defibrillator (AED) is for use by agency personnel specifically trained in the operation of the AED and qualified by training in basic cardiac life support or in other physician-authorized emergency medical response.

III. GUIDELINES:

A. Items Needed:

1. AED
2. Battery and spare battery
3. Defibrillation pads with connector cable
4. PC card (for Forerunner Heartstream Model, located in clinic setting)

B. Care and Maintenance:

1. Insert the battery if there is not one already in place in the AED. The battery should "click" when properly installed.

2. Battery Insertion Test (BIT) display will appear on the screen. This is a self-test the AED automatically puts itself through when activated.

    a. When using the AED in an emergency situation, press the on/off button twice to stop the BIT and activate the AED for use.
    b. Follow the voice prompts in an emergency.

3. If the AED requires attention and/or did not pass the BIT, a flashing red X will appear in the upper right corner window of the device or

verbal prompts (FRx). The AED will also emit a chirping beep, which indicates (FR2 only):

a. A low battery
b. The temperature for storage of the AED is outside of the range
c. A self-test error.

4. Remove and reinsert the battery and try again. If problems are still detected, contact:

For AED Clinic
Phillips
1-800-263-3342

C. PC Data Card Verification (FR2 only)

1. The BIT automatically verifies the presence of the PC data card. The screen will display card compatibility or incompatibility.

2. To install the PC data card:

a. Insert before installing battery.
b. Confirm that the card is clean, dry and free of any client identification labels.
c. Insert the PC data card in the slot with the arrow label facing upwards.
d. Push the card in until it is flush with the slot. Do not force – verify that the arrow label faces up.
e. Insert the battery and perform the BIT.

D. Preparation for use in an Emergency

1. Only individuals currently certified in BLS and AED use (American Heart Association or American Red Cross) are to utilize this device.

2. AED Special Considerations:

a. Note if the client is in or near standing water. Water is a good conductor of electricity and if a shock is delivered to a client in this situation, the rescuers and bystanders could receive an electrical shock or burns. Move the client if this situation exists and dry the skin well before proceeding with the use of an AED.
b. Verify that the client does not have a transdermal medication patch on the surface of the skin where the AED electrode pads will be applied. Should one be present, remove it and wipe the skin clean with a towel. The medication patch may

block energy from the electrode pad to the heart and may cause small burns to the skin.

c. Note if the client has an implanted device in his/her chest (pacemaker, defibrillator, or cardiac monitoring device) about half the size of a deck of cards, usually in the left upper chest area. If present, do not place the AED defibrillator pad over the device. The defibrillator pad is to be placed at least one inch to the side of the implanted device.

3. Remove or open any garments covering the client's chest.

4. Remove any hair that could prevent the defibrillator pads from adhering by sticking pads to chest and removing then applying new pads.

5. Open the package that contains the defibrillator pads and connector cables that plug into the AED.

6. Power on the AED.

7. Stop CPR while the defibrillator pads are being applied to assure proper placement on the client's chest.

   a. Place one defibrillator pad on the upper right sternal border (directly below the clavicle).
   b. Place the second defibrillator pad lateral to the left nipple with the top margin of the pad a few inches below the axilla.

8. Plug the cable connector into the AED.

E. Analysis and Monitoring

1. Once the pads are applied correctly, do not touch the client and allow AED analysis of data.

2. Follow all voice prompt instructions.

3. If a shock is advised, "clear" the client by instructing bystanders and those performing CPR not to touch the client and press the shock button. The AED can prompt a shock whenever any of these occur:

   a. A voice prompt instructs you to deliver a shock
   b. The shock button flashes
   c. You hear a steady tone
   d. You see a prompt on the AED screen instructing you to deliver a shock
   e. The AED <u>will not</u> automatically deliver a shock
   f. If the AED voice prompt states no shock is recommended, resume BLS until EMS arrives:

i) If the client has a pulse but is not breathing, resume rescue breathing.
ii) If the client has a pulse and is breathing, position in the recovery position and monitor.

g. After pressing the shock button, a voice prompt will confirm that the shock was delivered.
h. The voice prompt will instruct you not to touch the client while data is analyzed.
i. If a series of three unsuccessful shocks are delivered, the AED will pause for CPR to resume.
j. During the pause for CPR the AED screen will display the following information:
   i) A bar that fills as pause time elapses
   ii) Elapsed time since the AED was turned on and the number of shocks delivered.

F. Error, Corrective Action

1. When the AED detects an error during use it provides a voice prompt and screen display.

2. Please refer to the Reference Manual provided for each specific AED for problems and corrective actions.

G. Reviewing Incident Data – review the AED reference manual for more in-dept information.

1. If the AED has a data card (Forerunner Heartstream located in clinic setting), the card must be inserted prior to inserting the battery and using the AED.

2. Both AEDs have an internal memory which summarizes the incident and will display it on the screen:

   a. How long the incident recorded by the AED lasted; and
   b. How many shocks were delivered during the incident.

3. This information can be retrieved from the internal memory until the AED is used for the next emergency.

H. Recommended Maintenance Schedule

1. Daily and after each use:

   a. Check the status indicator, should see alternating black hourglass and black screen that indicates the AED is ready for use or blinking green light.

b. Ensure the AED is stored properly and is undamaged and clean.
c. Replace used/damaged equipment by contacting appropriate company in reference manual.

2. Weekly and after each use: Ensure that exterior and connector socket is free of cracks/damage.

I. Cleaning

1. Clean only with the battery installed to keep cleaning solutions/products out of the battery area.

2. Use a soft cloth. Do not use abrasive products or strong solvents such as acetone or acetone-based cleaners.

3. Do not immerse AED in any fluids.

4. Clean AED with appropriate cleaning agents such as:

a. Isopropyl alcohol (70% solution)
b. Chlorine bleach
c. Ammonia based cleaners
d. Glutaraldehyde based cleaners

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

NURSING ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A.	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B.	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Fire Extinguishers c. Exit signs d. Security e. Tornado plan f. Emergency preparedness • Automatic External Defibrillator • PHN Disaster training • PHN Disaster assistance • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for: 1. CPR 2. Automatic External Defibrillator 3. Infection Control		
	3. Infection control a. Personal Hygiene b. Aseptic Technique		

	c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and handling supplies g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB Skin Test • Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management • Vaccine Transporting, handling and storage k. Identifying, handling, and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable Gown • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Screening and reporting for child and adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education Requirements		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Committee and purpose 2. Call supervisor by 7:00am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Quarterly Audits c. Incident Reports d. Blood borne pathogen Exposure e. Client Complaints f. CPT/ICD 10		
D.	Preceptor Assigned		
E.	Orientation period		
F.	Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable)		

	4. Scope of services and program policy review 5. Client Medical Record a. Charting System- Electronic Health Record (see EHR policy Adm-33) b. Nursing documentation • How obtain physician's orders • Standing orders • Lab reports • Consent forms/Release of Information • Agency approved abbreviations • Client referral forms • Follow-up of abnormal findings • Encounter forms 6. Documentation tips a. Use good grammar, spelling and punctuation b. Notes are signed, titled, and dated in EHR c. When teaching, document what was taught, to whom it was taught any return demonstrations, and client/caregiver's understanding d. Identify chief complaints to correlate with client's presenting symptoms e. Identify client diagnoses that correlate with problems evidenced. f. Use quotes or the client's own words. Document FACTUAL, ACCURATE, COMPLETE, AND TIMELY g. Document the name of interpreter used h. Use only agency-approved abbreviations i. Document signs, symptoms and observations related to the physiology and course of the disease process. j. Include the following information when analyzing a symptom: Onset, predisposing factors, characteristics, location of pain, intensity, severity, aggravating or relieving factors, associated symptoms, course since onset, incidence, and effect of therapy. k. Avoid words like stable, no change, doing well, no problems and no complaints l. Educate clients on the services and requirements of program.		
	7. Documentation Don'ts a. Don't get personal, don't use derogatory references, don't keep secrets b. Don't document your own personal judgments c. Identify in your notes what physician was seen by the client, identify what physician you contacted, etc. don't document "MD NOTIFIED"		

	8. Expectations of the Nursing role a. Report to clinic as assigned in a timely manner b. Review medical record prior to client contact c. Introduce self to client and state purpose d. Use appropriate communication skills e. Assess needs, health history and current status/document appropriately f. RN's – Implement and document problems based on assessment g. RN's – Implements, carries out and document appropriate care treatment h. LPN's – Perform delegated nursing activities such as participating in assessment of client's physical and mental health, recording reporting results of the nursing assessments, participates in the implementation of the health care plan as developed by the RN and/or as prescribed by any person authorized by State Law to prescribe such a plan, reinforcing the teaching and counseling of a registered nurse, or physician, reporting and recording the nursing care provided and client's response to that care i. Accounts for all work hours through sign-out sheets, leave records, and time sheets j. Reviews and updates job description annually k. Adheres to dress code – displaying a professional appearance l. Establishes an effective working relationship with others m. Reliable in following procedures/policies n. Provides nursing services to clients according to standards, program guidelines and collaborates with other health care disciplines o. Treats public with courtesy and respect p. Maintains complete confidentiality of client information		
	9. Accreditation process – development, implementation and maintenance		

Employee Signature: _____Date_____

Supervisor Signature: _____ Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.

- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible**.**

Date Developed: 2002
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/15

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

ADVANCED PRACTICE PROVIDER ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Fire Extinguishers c. Exit signs d. Security e. Tornado plan f. Emergency preparedness • Automatic External Defibrillator • PHN Disaster training • PHN Disaster assistance • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for: 1. CPR 2. Automatic External Defibrillator 3. Infection Control		
	3. Infection control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease		

	d. Cleaning, Disinfecting, Transporting Equipment e. Storing and handling supplies f. Standard Precautions g. Blood borne pathogens h. Vaccinations • TB Skin Test • Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella i. Identifying, handling, and disposing of hazardous materials j. Safety Data sheets k. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable Gown • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Screening and reporting for child and adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education Requirements		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Council and purpose 2. Call supervisor by 7:00am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Quarterly Audits c. Incident Reports d. Blood borne pathogen Exposure e. Client Complaints f. CPT/ICD 10		
D	Preceptor Assigned		
E	Orientation period		
F	Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable) 4. Scope of services and program policy review Scope of Practice – 32M.0102 Licensing – board of Medical Examiners a. The Nurse Practitioner/Physician Assistant shall		

	be responsible and accountable for the continuous and comprehensive management of a broad range of personal health services for which the Nurse Practitioner is educationally prepared and for which competency has been maintained, with physician supervision and collaboration as described in *21 NCAC 32M.0109.* These services include, but are not restricted to: • Promotion & maintenance of health • Prevention of illness & disability • Diagnosing, treating and managing acute & chronic illnesses • Guidance and counseling for both individuals & families • Prescribing, administering and dispensing therapeutic measures, tests, procedures and drugs • Planning for situations beyond the nurse practitioner's expertise and consulting with and referring to other health care providers as appropriate • Evaluating health outcomes 5. Client Medical Record a. Charting System- Electronic Health Record (see EHR policy Adm-33) b. Advanced Practice Provider (APP) documentation • How obtain physician's orders • Standing orders • Lab reports • Consent forms/Release of Information • Agency approved abbreviations • Client referral form • Follow-up of abnormal findings • Encounter forms 6. Documentation tips a. Use good grammar, spelling and punctuation b. Notes are signed, titled, and dated in EHR c. When teaching, document what was taught, to whom it was taught any return demonstrations, and client/caregiver's understanding d. Use quotes or the client's own words. Document FACTUAL, ACCURATE, COMPLETE, AND TIMELY e. Identify chief complaints to correlate with client's presenting symptoms f. Identify client diagnoses that correlate with problems evidenced. g. Document the name of interpreter used		

	h. Use only agency-approved abbreviations i. Document signs, symptoms and observations related to the physiology and course of the disease process. j. May include the following information when analyzing a symptom: Onset, predisposing factors, characteristics, location of pain, intensity, severity, aggravating or relieving factors, associated symptoms, course since onset, incidence, and effect of therapy. k. Use key words and phrases such as: unstable, deteriorating, improving, change in, learning, taught, instructed, observed, evaluated, new problem, concerned about, complains of, needs assistance with, monitored l. Educate clients on going to the services and requirements of program.		
	7. Documentation Don'ts a. Don't get personal, don't use derogatory references, don't keep secrets b. Don't document your own personal judgments c. Identify in your notes what physician was seen by the client, identify what physician you contacted, etc. don't document "MD NOTIFIED"		
	8. Expectations of the APP role a. Report to clinic as assigned in a timely manner b. Review medical record prior to client contact c. Introduce self to client and state purpose d. Use appropriate communication skills e. Assess needs, health history and current status/document appropriately f. APP - implement and document problems based on assessment g. APP – Implements, carries out and document appropriate care treatment h. APP – accurately and safely diagnoses and dispenses medical treatment based on supervising physician's standing orders i. APP has been approved to give medical diagnosis, order therapy, prescribe medications as outlined in the approved formulary j. APP's work may be performed in a specialized area or in a generalized area through a wide variety of settings k. APP satisfactorily participates in evaluation, development, and implementation of policies and procedures		

l. The Primary Supervising Physician and the Nurse Practitioner will develop a procedure for reviewing the care provided. This process will include a written plan for evaluating the quality of care provided.
m. This process will include:
    - A description of the clinical problem
    - An evaluation of treatment interventions
    - A plan for improving outcomes with a time-frame established
n. Prescribing Authority for APP
o. Drugs and devices prescribed shall be included in written protocols
p. The APP has an assigned DEA number which is entered on each prescription for a controlled substance
q. The Nurse Practitioner may prescribe a drug not included in the agency written protocols only as:
r. Upon a specific written or verbal order obtained form a primary or backup supervising physician before the prescription or order is issued
s. And the written or verbal order is entered into the client record with a notation that it is issued on the specific order of a primary or back-up supervising physician and signed by the nurse practitioner and the physician
t. Each prescription shall be noted on the client's chart & include the following information: medication & dosage, amount prescribed, directions for use, number of refills and signature of NP or PA
u. The prescribing number assigned by the Medical Board to the Nurse Practitioner must appear on all prescriptions issued
v. All prescriptions issued by NP shall contain the supervising physician's name, the name of the client, and the nurse practitioner's name, telephone number, and prescribing number
w. Each prescription issued by a PA shall contain the PA's name, practice address, and telephone number, the PA's license number and PA's DEA registration number for controlled substances, and the supervising physician's name and telephone number

	x. The NP's and PA's assigned DEA number shall be written on the prescription form when a controlled substance is prescribed. The supervising physician & PA both have a valid DEA registration for the PA to prescribe controlled substances y. The Primary or back-up supervising physician(s) and the NP shall be continuously available to each other for consultation by direct communication or telecommunication z. Accounts for all work hours, through sign-out sheets, leave records, and time sheets aa. Reviews and updates job description annually bb. Adhere to dress code – displaying a professional appearance cc. Establishes an effective working relationship with others dd. Reliable in following procedures/policies ee. Provides APP care to clients according to APP standards, program guidelines and collaborates with other health care discipline ff. Treats public with courtesy & respect gg. Maintains complete confidentiality of client information		
	9. Accreditation Process – development, implementation, and maintenance.		
G	Quality Improvement Process for Nurse Practitioner: The primary supervising physician and the nurse practitioner shall develop a process for the on-going review of the care provided in each practice site to include a written plan for evaluating the quality of care provided for one or more frequently encountered clinical problem; and this plan shall include a description of the clinical problem(s), an evaluation of the current treatment interventions, and if needed, a plan for improving outcomes within an identified time-frame 1. Will include scheduled meetings between the primary supervising physician and the nurse practitioner at least every six months. Documentation for each meeting shall: a. Identify clinical problems discussed which also includes progress toward improving outcomes and recommendations for changes in treatment plan b. Be signed and dated by those attending c. Be available for review within five calendar years and be retained by both the nurse		

practitioner and the physician

2. Physician Assistant
    a. All policies, standing orders, and program triage resources will be reviewed and updated yearly. The supervising physician will sign these annually
3. Nurse Practitioner – Physician Consultation-minimum Standards: The minimum standard for consultation between the nurse practitioner and the primary or back-up supervising physician
    a. The nurse practitioner with temporary approval
        - Review & countersign of notations by the primary or back-up supervising physician for selected charts.
        - Face to face consultation with the primary supervising physician on a weekly basis for one month after temporary approval is achieved at least monthly throughout the period of temporary approval
    b. The nurse practitioner with first time approval for practice
        - Reviewing & countersigning notations of medical acts by a primary or back-up supervising physician for selected charts
        - Face to face consultation with the primary supervising physician on a weekly basis for one month after full approval is received and at least monthly for a period no less than the succeeding five months
4. The nurse practitioner previously approved to practice in NC who changes primary supervising physician shall have face to face consultation with the primary supervising physician weekly for one month and then monthly for the succeeding five months
    a. Documentation of consultation shall:
        - Identify clinical issues discussed and actions taken
        - Be signed and dated by those who attended
        - Be available for review by the Board for previous five calendar years and be retained by both the nurse practitioner and the physician
5. Written protocols shall be agreed upon and signed by both the primary supervising physician and the APP, and maintained in each practice site
    a. Written protocols shall be reviewed at least yearly, and this review shall be acknowledged by a dated signature sheet, signed by both the primary supervising physician and the APP, appended to the written protocol and available

	for inspection by members or agents of either Board b. The Written protocols shall include the drugs, devices, medical treatment, tests and procedures that may be prescribed, ordered and implemented by the APP and which are appropriate for the diagnosis and treatment of most commonly encountered health problems in that practice setting c. The written protocols shall include a pre-determined plan for emergency services d. The APP shall be prepared to demonstrate the ability to perform medical acts as outlined in the written protocols upon request by members or agents of either Board e. The APP shall wear an appropriate name tag spelling out the words "Nurse Practitioner" or "Physician Assistant"		
	6. The Primary Supervising Physician and the APP will develop a procedure for reviewing the care provided. This process will include a written plan for evaluating the quality of care provided a. This process will include: • A description of the clinical problem • An evaluation of treatment interventions • A plan for improving outcomes with a timeframe established b. The QA process shall include scheduled meetings between the Primary Supervising Physician and the Nurse Practitioner at least every 6 months. The documentation of these meetings shall be signed & dated by those attending, and shall be available for the previous 5 calendar years c. Physician Assistant – the supervising physician may co-sign the Physician Assistants records. This process is arranged mutually between the PA and the supervising physician		

These standards were referenced according to the "Medical Practice Act NCGS, Chapter 90; Nursing Practice Act.

Employee Signature: _____ Date_____

Supervisor Signature: _____ Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.
- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible.

Date Developed: 2002
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/15

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

FCC SOCIAL WORKER ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A.	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B.	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Fire Extinguishers c. Exit signs d. Security e. Tornado plan f. Emergency preparedness • Automatic External Defibrillator • PHN Disaster training • PHN Disaster assistance • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for: 1. CPR 2. Automatic External Defibrillator 3. Infection Control		
	3. Infection control a. Personal Hygiene b. Aseptic Technique		

	c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and handling supplies g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB Skin Test • Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella j. Identifying, handling, and disposing of hazardous materials k. Safety Data sheets l. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable Gown • Vent Mask • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Screening and reporting for child and adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Council and purpose 2. Call supervisor by 7:00am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Audits c. Incident Reports d. Blood borne pathogen Exposure e. Client Complaints		
D.	Preceptor Assigned		
E.	Orientation period		
F.	Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule 4. Scope of services and program policy review		

	5. Client Record - Charting System • All documentation will occur in Virtual Health System (VH) • Task notes, assessments, and screenings will be entered into VH • All entries into VH will occur no more than 72 hours after the task took place 6. Documentation tips a. Entries should use good grammar, spelling and punctuation b. VH will sign, title and date each entry c. When teaching, chart what was taught, to whom it was taught any return demonstrations, and client/caregiver's understanding d. Use quotes or the client's own words. Chart factual, accurate, complete and timely e. Document the name of interpreter used f. Use only agency and program approved abbreviations g. Chart all notes related to medical, social, or psychological issues/concerns in patient CNA-CMARC and CNA-CMHRP (whichever is applicable) versus in task notes		
	7. The Family Care Coordination Social Worker's role a. Report to clinic as assigned in a timely manner b. Accounts for all work hours through sign-out sheets, leave records, and time sheets c. Reviews and updates job description annually d. Adheres to dress code – displaying a professional appearance e. Establishes an effective working relationship with others f. Reliable in following procedures/policies g. Treats public with courtesy and respect h. Maintains complete confidentiality of client information		
	8. Accreditation Process – development, implementation, and maintenance		

Employee Signature: _____Date_____

Supervisor Signature: _____ Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.
- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible.

Date Developed: 2002
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

MEDICAL LABORATORY ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A.	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B.	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Fire Extinguishers c. Exit signs d. Security e. Tornado plan f. Emergency preparedness • Automatic External Defibrillator • Medical Lab Disaster Training • Medical Lab Disaster Assistance • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for: 1. CPR 2. Automatic External Defibrillator 3. Infection Control		
	3. Infection control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease		

	d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and handling supplies g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB Skin Test • Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management – QA Reports k. Identifying, handling, and disposing of hazardous materials l. Safety Data sheets m. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable Gown • Vent Mask • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Screening and reporting for child and adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education Requirements		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Council Committee and purpose 2. Call supervisor by 7:00 am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Quarterly Audits c. Incident Reports d. Blood Borne Pathogen Exposure e. Client Complaints f. Temperatures for: • Room incubator • Refrigerator g. Daily maintenance h. Clean counter end of shift i. Controls (all tests) done 1 x day j. Check in all daily labs & review k. Check supplies daily		

	l. End of day, file lab requisitions m. Review reports for 24 hour, 48 hour, 72 hour – for GC plates n. On Monday-Wednesday-Friday CS patient plates are read for specimens obtained o. CPT/ICD 9 - Chargeable - Non-Chargeable		
D.	Preceptor Assigned		
E.	Orientation period		
F.	Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable) 4. Pager system 5. Scope of services and program policy review 6. Client Medical Record a. Charting System- Electronic Health Record (EHHR) See EHHR Policy ADM-33 b. Chart room – and procedure for retrieval c. Nursing documentation • How obtain physician's orders • Standing orders • Lab reports • Consent forms/Release of Information • Consent to photograph • Agency approved abbreviations • Client referral form • Follow-up of abnormal findings • Encounter forms 7. Documentation tips a. Use good grammar, spelling and punctuation b. Notes are signed, titled, and dated in EHR c. When teaching, document what was taught, to whom it was taught, any return demonstrations, and client/caregiver's understanding d. Use quotes or the client's own words. Document FACTUAL, ACCURATE, COMPLETE, AND TIMELY e. Document the name of interpreter used f. Use only agency-approved abbreviations g. Document signs, symptoms and observations related to the physiology and course of the disease process. h. Include the following information when analyzing a symptom: Onset, predisposing factors, characteristics, location of pain, intensity, severity, aggravating or relieving factors, associated symptoms, course since onset, incidence, and effect of therapy. i. Avoid words like stable, no change, doing well,		

	no problems and no complaints. Key words and phrases to use, unstable, deteriorating, improving, change in, learning, taught, instructed, observed, evaluated, new problem, concerned about, complains of, needs assistance with, monitored j. Educate clients on going to the services and requirements of program.		
	8. Documentation Don'ts a. Don't get personal, don't use derogatory references, don't keep secrets b. Don't document your own personal judgments c. Identify in your notes what physician was seen by the client, identify what physician you contacted, etc. don't document "MD NOTIFIED"		
	9. Expectations of the Medical Laboratory Role: a. Report to clinic as assigned in a timely manner b. Review medical record prior to client contact c. Introduce self to client and state purpose d. Use appropriate communication skills e. Assess needs, health history and current status/document appropriately f. Implement, carry out, and document appropriate care/treatment g. Accounts for all work hours through sign-out sheets, leave records, time sheets and mileage sheets h. Reviews and updates job description annually i. Adheres to dress code – displaying a professional appearance j. Establishes an effective working relationship with others k. Reliable in following procedures/policies l. Provides medical lab services to clients according to medical lab standards, program guidelines and collaborates with other health care disciplines m. Treats public with courtesy and respect n. Maintains complete confidentiality of client information 10. Accreditation process – development, implementation and maintenance		

Employee Signature: _____ Date_____

Supervisor Signature: _____ Date_____

Employee Signature: _____ Date_____

Supervisor Signature: _____ Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.
- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible.

Date Developed: 2002
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/15

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

MEDICAL OFFICE ASSISTANT ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A.	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B.	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Fire Extinguishers c. Exit signs d. Security e. Tornado plan f. Emergency preparedness • Automatic External Defibrillator • Medical Office Assistant Disaster Training • Medical Office Assistant Disaster Assistance • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for: 1. CPR 2. Automatic External Defibrillator 3. Infection Control		
	3. Infection control a. Personal Hygiene b. Aseptic Technique		

	c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and handling supplies g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB Skin Test • Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management • Vaccine transporting • Handling & Storage k. Identifying, handling, and disposing of hazardous materials l. Safety Data sheets m. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable Gown • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Screening and reporting for child and adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education Requirements		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Council and purpose 2. Call supervisor by 7:00 am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Quarterly Audits c. Incident Reports d. Bloodborne Pathogen Exposure e. Client Complaints f. CPT/ICD 10		
D.	Preceptor Assigned		
E.	Orientation period		
F.	Program Area 1. Introduction to worksite 2. Introduction to program		

	3. Schedule – M-F and on-call (if applicable) 4. Scope of services and program policy review 5. Client Medical Record a. Charting System- Electronic Health Record (see EHR Policy ADM-33) b. Chart Rom – and procedure for retrieval c. Documentation • How obtain physician's orders • Standing orders • Lab reports • Consent forms/Release of Information • Consent to photograph • Agency approved abbreviations • Client referral form • Follow-up of abnormal findings • Encounter forms 6. Documentation tips a. Use good grammar, spelling and punctuation b. Notes are signed, titled, and dated in EHR c. When teaching, document what was taught, to whom it was taught, any return demonstrations, and client/caregiver's understanding d. Use quotes or the client's own words. Document FACTUAL, ACCURATE, COMPLETE, AND TIMELY e. Document the name of interpreter used f. Use only agency-approved abbreviations g. Document signs, symptoms and observations related to the physiology and course of the disease process. h. Include the following information when analyzing a symptom: Onset, predisposing factors, characteristics, location of pain, intensity, severity, aggravating or relieving factors, associated symptoms, course since onset, incidence, and effect of therapy. i. Avoid words like stable, no change, doing well, no problems and no complaints. Key words and phrases to use, unstable, deteriorating, improving, change in, learning, taught, instructed, observed, evaluated, new problem, concerned about, complains of, needs assistance with, monitored j. Educate clients on going to the services and requirements of program.		
	7. Documentation Don'ts a. Don't get personal, don't use derogatory references, don't keep secrets b. Don't document your own personal judgments c. Identify in your notes what physician was seen by the client, identify what physician you contacted,		

	etc. don't document "MD NOTIFIED"		
	8. Expectations of the Medical Office Assistant a. Report to clinic as assigned in a timely manner b. Review medical record prior to client contact c. Introduce self to client and state purpose d. Use appropriate communication skills e. Assess needs, health history and current status/document appropriately f. Implement and document problems based on assessment g. Accounts for all work hours through sign-out sheets, leave records, time sheets and mileage sheets h. Reviews and updates job description annually i. Adheres to dress code – displaying a professional appearance j. Establishes an effective working relationship with others k. Reliable in following procedures/policies l. Provides Medical Office Assistant services to clients according to standards, program guidelines and collaborates with other health care disciplines m. Treats public with courtesy and respect n. Maintains complete confidentiality of client information 9. Accreditation process – development, implementation and maintenance		

Employee Signature: _____ Date_____

Supervisor Signature: _____ Date_____

Employee Signature: _____ Date_____

Supervisor Signature: _____ Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.
- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible.

Date Developed: 2002
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/15

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

INTERPRETER ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A.	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B.	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Fire Extinguishers c. Exit signs d. Security e. Tornado plan f. Emergency preparedness • Automatic External Defibrillator • Interpreter Disaster Training • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for: 1. CPR 2. Automatic External Defibrillator 3. Infection Control		
	3. Infection Control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment		

	f. Storing and handling supplies g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB Skin Test • Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management • Vaccine transporting • Handling & Storage k. Identifying, handling, and disposing of hazardous materials l. Safety Data sheets m. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable Gown • Vent Mask • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Screening and reporting for child and adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education Requirements		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Council and purpose 2. Call supervisor by 7:00 am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Quarterly Audits c. Incident Reports d. Bloodborne Pathogen Exposure e. Client Complaints f. CPT/ICD - Chargeable - Non-Chargeable		
D.	Preceptor Assigned		
E.	Orientation period		
F.	Program Area 1. Introduction to worksite 2. Introduction to program		

	3. Schedule – M-F and on-call (if applicable) 4. Pager system 5. Scope of services and program policy review 6. Client Medical Record a. Chart Room – and procedure for retrieval b. Electronic Health Record (EHR) 7. Interpretation Documentation Rules a. It is inappropriate to use county interpreters to complete the actual medical record. This would include the history, flow sheet, or any and all documentation pertaining to the services that are rendered or interviews conducted while the client is being seen for services throughout the health department. b. The NC Office of Minority Health has issued further guidance in how to effectively utilize interpreter services. The following applies: *The provider must rely on the third party as the interpreter to convey the information, thoughts, and opinions. *The interpreter must have a thorough understanding of both the target language and the source language. In addition, the interpreter must be familiar with the culture and traditions of both. *The interpreter should speak in first person and avoid saying "he" or "she" says. This allows the provider and client to speak directly to each other. *Consecutive Interpretation allows one to speak in short sentences and pause while the interpreter repeats what is said. *The provider should look directly at the client and not the interpreter when speaking. *It is not appropriate to delegate the responsibility of interviewing to the interpreter. *It is not appropriate to allow the interpreter to document responses on the chart. *The role of the interpreter is to translate every word said in the room and not to assume that because they can interpret that they can complete the medical forms. *The interpreter should sign their name to all documentation after the provider's name to indicate who the interpreter was that assisted with the interview.		
	8. Expectations of the Interpreter Role: a. Report to clinic as assigned in a timely manner b. Introduce self to client and state purpose c. Use appropriate communication skills d. Assess needs, health history and current status/document appropriately		

	e. Implement and document problems based on assessment f. Accounts for all work hours through sign-out sheets, leave records, time sheets and mileage sheets g. Reviews and updates job description annually h. Adheres to dress code – displaying a professional appearance i. Establishes an effective working relationship with others j. Reliable in following procedures/policies k. Provides Interpreter services to clients according to standards, program guidelines and collaborates with other health care disciplines l. Treats public with courtesy and respect m. Maintains complete confidentiality of client information 9. Accreditation process – development, implementation and maintenance		

Employee Signature: _____Date_____

Supervisor Signature: _____ Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.
- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible.

Date Developed: 2002
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/15

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

COMMUNICABLE DISEASE NURSE ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A.	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B.	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Smoke sensors c. Fire Extinguishers d. Exit signs e. Security f. Tornado plan g. Emergency preparedness • Automatic External Defibrillator • PHN Disaster Training • PHN Disaster Assistance • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for: 1. CPR 2. Automatic External Defibrillator 3. Infection Control		
	3. Infection control a. Personal Hygiene b. Aseptic Technique		

	c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and handling supplies g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB Skin Test • Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella or titer j. Equipment Management • Vaccine transporting, handling and storage k. Identifying, handling, and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable Gown • Vent Mask • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Screening and reporting for child and adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education Requirements		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Council and purpose 2. Call supervisor by 7:00am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Quarterly Audits c. Incident Reports d. Blood borne pathogen Exposure e. Client Complaints f. CPT/ICD 10 • Chargeable • Non-Chargeable		
D.	Preceptor Assigned		
E.	Orientation period		
F.	Program Area		

	1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable) 4. Pager system 5. Scope of services and program policy review 6. Client Medical Record a. Charting System-Electronic Health Record (see EHR Policy ADM-33) b. Chart room – and procedure for retrieval c. Nursing documentation • How obtain physician's orders • Standing orders • Lab reports • Consent forms/Release of Information • Agency approved abbreviations • Client referral form • Follow-up of abnormal findings • Encounter forms 7. Documentation tips a. Use good grammar, spelling and punctuation b. Notes are signed, titled, and dated in EHR c. When teaching, document what was taught, to whom it was taught, any return demonstrations, and client/caregiver's understanding d. Identify chief complaints to correlate with client's presenting symptoms e. Identify client diagnoses that correlate with problems evidenced and list on problem list. Keep problem list current f. Use quotes or the client's own words. Document FACTUAL, ACCURATE, COMPLETE, AND TIMELY g. Document the name of interpreter used h. Use only agency-approved abbreviations i. Document signs, symptoms and observations related to the physiology and course of the disease process. j. Include the following information when analyzing a symptom: Onset, predisposing factors, characteristics, location of pain, intensity, severity, aggravating or relieving factors, associated symptoms, course since onset, incidence, and effect of therapy. k. Avoid words like stable, no change, doing well, no problems and no complaints l. Educate clients on going to the services and requirements of program.		
	8. Documentation Don'ts a. Don't get personal, don't use derogatory references, don't keep secrets b. Don't document your own personal judgments c. Identify in your notes what physician was seen by the		

	client, identify what physician you contacted, etc. don't document "MD NOTIFIED"		
	9. Expectations of the Communicable Disease Nursing role a. Report to clinic as assigned in a timely manner b. Review medical record prior to client contact c. Introduce self to client and state purpose d. Use appropriate communication skills e. Assess needs, health history and current status/ document appropriately f. RN's – Implement and document problems based on assessment g. RN's – Implements, carries out and document appropriate care treatment h. LPN's – Perform delegated nursing activities such as participating in assessment of client's physical and mental health, recording reporting results of the nursing assessments, participates in the implementation of the health care plan as developed by the RN and/or as prescribed by any person authorized by State Law to prescribe such a plan, reinforcing the teaching and counseling of a registered nurse, or physician, reporting and recording the nursing care provided and client's response to that care i. Accounts for all work hours through sign-out sheets, leave records, time sheets and mileage sheets j. Reviews and updates job description annually k. Adheres to dress code – displaying a professional appearance l. Establishes an effective working relationship with others m. Reliable in following procedures/policies n. Provides nursing services to clients according to standards, program guidelines and collaborates with other health care disciplines o. Treats public with courtesy and respect p. Maintains complete confidentiality of client information 10. Accreditation process – development, implementation and maintenance 11. Communicable Disease Manual a. Completion of Communicable Disease Surveillance via NC Electronic Data Surveillance System (NCEDSS) b. Communicable Disease Line Listing Report c. Hepatitis B Log/tickler/NCEDSS d. Hepatitis C Log/tickler/NCEDSS 12. The North Carolina TB Policy Manual a. Is knowledgeable about NC TB Control policies as set forth in manual/website		

	b. Is knowledgeable about local TB control policies c. Demonstrates correct use of TB documents in EHR: 1. Tuberculosis Drug Record 2. Tuberculosis Flow Sheet 3. Tuberculosis Epidemiological Record 4. Nursing record of Tuberculosis Contacts 5. Understands how to proceed when a Refugee Notification of Arrival notice is received d. Record of Tuberculosis Screening Demonstrates knowledge of TB case management: 1. Organizes and prioritizes workload 2. Works with private or health department provider to develop a treatment plan and obtain physician's orders 3. Makes initial hospital and/or home assessment and subsequent home visits as needed 4. Is knowledgeable about cultural/language barriers including reading ability and obtains the services of an interpreter when needed 5. Provides or arranges for DOT 6. Directs and supervises a contact investigation (CI) for laryngeal and pulmonary TB cases within accepted time frame 7. Utilizes the concentric circle method for CIs 8. Provides follow-up care for TB cases/suspects/TLTBI based on state policy and individual's needs 9. Documents activities clearly, accurately and timely in EHR 10. Is knowledgeable about policy for clients lost to follow-up 11. Is able to correctly place and read a PPD e. Has read and understands the General Statutes for the control measures for communicable disease GS 130A-144 and NC Administrative Code s10A NCAC 41A .0205 f. Is knowledgeable about how to initiate a TB Treatment Agreement and/or an Isolation Order g. Is knowledgeable on how to report a TB Case to NC TB Control h. Is knowledgeable about incarceration procedures for health law violators i. Administers intramuscular injections properly j. Performs venipunctures correctly k. Is able to perform vision test for acuity and colorblindness l. Is able to perform basic audiometry tests for hearing acuity m. Is knowledgeable of baseline testing requirements n. Is knowledgeable about infection control measures,		

	including how to use a N-95 respirator, elements of a tuberculosis infection control policy and risk classifications o. Is knowledgeable about x-ray findings that may indicate TB p. Is knowledgeable about how to order TB medications through NC TB Control q. Is knowledgeable about TB medications including side effects, drug interactions, especially with HIV/AIDS medications, mental health medications, and contraceptives r. Teaches client/family/significant others about: 1. Confidentiality 2. DOT for TB cases/suspects/and some TLTBI 3. Transmission/pathogenesis of infection and disease 4. Difference between infection and disease 5. Prevention of spread of TB 6. Process of contact investigation and identification of source case if child or HIV/AIDS client involved 7. Purpose and importance of LTBI treatment for contacts 8. Importance of regular ingestion of TB medications for both active disease and LTBI treatment 9. Importance of completing full-course of treatment to cure 10. Importance of at least monthly medication and monitoring visits with TB Nurse to assess progress, adherence and side effects 11. Signs/symptoms of TB disease to report to RN including hemoptysis, sputum production, weight loss, fatigue and/or failing to clinically improve 12. Provides written literature about TB to client (in language client can understand) 13. Teaches client/family/significant others about TB medications and interactions with other medicines 14. Discusses side effects such as fever, GI disturbances, loss of appetite, skin rash/itching, numbness/tingling of hands and feet, and headache 15. Counsels client on the importance of HIV testing and performs test with client consent. Refers client for appropriate follow-up if HIV positive and obtains CD4 count s. Knowledgeable about appropriate resources for clients such as ALA incentive and housing funds t. Is aware of NC TB Control educational materials and how to obtain these materials		

Employee Signature: _____ Date_____

Supervisor Signature: _____ Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.
- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible.

Date Developed: 3/04
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/15

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

FAMILY CARE COORDINATION (FCC) NURSING ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A.	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B.	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Fire Extinguishers c. Exit signs d. Security e. Tornado plan f. Emergency preparedness • Automatic External Defibrillator • PHN Disaster training • PHN Disaster assistance • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for: 1. CPR 2. Automatic External Defibrillator 3. Infection Control		
	3. Infection control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease		

	d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and handling supplies g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB Skin Test • Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management • Vaccine Transporting, handling and storage k. Identifying, handling, and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable Gown • Vent Mask • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Screening and reporting for child and adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education Requirements		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Council and purpose 2. Call supervisor by 7:00am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Audits c. Incident Reports d. Blood borne pathogen Exposure e. Client Complaints		
D.	Preceptor Assigned		
E.	Orientation period		
F.	Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F and on-call (if applicable) 4. Pager system		

	5. Scope of services and program policy review 6. Client Record - Charting System • All documentation will occur in Virtual Health (VH) • Task notes, assessments, and screenings will be entered into VH • All entries into VH will occur no more than 72 hours after the task took place 7. Documentation tips a. Entries should use good grammar, spelling and punctuation b. When teaching, chart what was taught, to whom it was taught any return demonstrations, and client/caregiver's understanding c. Use quotes or the client's own words. Chart factual, accurate, complete and timely d. Document the name of interpreter used e. Use only abbreviations approved by Community Care of N.C. (CCNC) f. Chart all notes related to medical, social, or psychological issues/concerns in patient Comprehensive Needs Assessment (CNA)		
	8. Expectations of the FCC Nurse's role: a. Report to clinic as assigned in a timely manner b. Accounts for all work hours through sign-out sheets, leave records, and time sheets c. Reviews and updates job description annually d. Adheres to dress code – displaying a professional appearance e. Establishes an effective working relationship with others f. Review chart prior to client contact g. Introduce self to client and state purpose h. Use appropriate communication skills i. Assess needs, health history and current status/ document appropriately j. RN's – Implement and document problems based on assessment k. RN's – Implements, carries out and document appropriate care treatment, if applicable l. Reliable in following procedures/policies m. Provides services to clients according to standards, program guidelines and collaborates with other disciplines n. Treats public with courtesy and respect o. Maintains complete confidentiality of client information		
	9. Accreditation process – development, implementation and maintenance		

Employee Signature: _____Date_____

Supervisor Signature: _____Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.
- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible.

Date Developed: 3/13
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/19

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

MEDICATION FOR OPIOID USE DISORDER (MOUD) COUNSELOR ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A.	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B.	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Fire Extinguishers c. Exit signs d. Security e. Tornado plan f. Emergency preparedness • Automatic External Defibrillator • PHN Disaster training • PHN Disaster assistance • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Home Visiting/Field Work c. Vehicle Safety d. Threatening Behavior e. Medical Emergencies • Clients • Employees • Staff training for: 1. CPR 2. Automatic External Defibrillator 3. Infection Control		
	3. Infection control a. Personal Hygiene		

	b. Aseptic Technique c. Communicable Disease d. Precautions e. Storing and handling supplies f. Standard Precautions g. Blood borne pathogens h. Vaccinations • TB Skin Test • Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella i. Identifying, handling, and disposing of hazardous materials j. Safety Data sheets k. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable Gown • Vent Mask • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Screening and reporting for adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Council and purpose 2. Call supervisor by 7:00 am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Audits c. Incident Reports d. Blood borne pathogen Exposure e. Client Complaints		
D.	Preceptor Assigned		
E.	Orientation period		
F.	Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule 4. Scope of services and program policy review 5. Client Record - Charting System		

	• All documentation will occur in EMR system • Task notes, assessments, and screenings will be entered into EMR • All entries into EMR will occur no more than 24 hours after the task took place 6. Documentation tips a. Entries should use good grammar, spelling and punctuation b. EMR will sign, title and date each entry c. Use quotes or the client's own words. Chart factual, accurate, complete and timely d. Document the name of interpreter used e. Use only agency and program approved abbreviations f. Chart all notes related to medical, social, or psychological issues/concerns in patient in appropriate documentation formats		
	7. The MOUD counselors' role a. Report to clinic as assigned in a timely manner b. Accounts for all work hours through sign-out sheets, leave records, and time sheets c. Reviews and updates job description annually d. Adheres to dress code – displaying a professional appearance e. Establishes an effective working relationship with others f. Reliable in following procedures/policies g. Treats public with courtesy and respect h. Maintains complete confidentiality of client information		
	8. Accreditation Process – development, implementation, and maintenance		

Employee Signature: _____Date_____

Supervisor Signature: _____ Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.
- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible.

Date Developed: 2024
Reviewed: 6/24
Revised:

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

NURSING SKILLS CHECKLIST

Employee Name: _____

Observer/Preceptor: _____

Date: _____

INITIAL/ANNUAL COMPETENCY VALIDATION CHECKLIST:

The above staff member has demonstrated the knowledge, skills, and attitudes necessary to provide care appropriate to the age of the patients served on his/her assigned unit. The individual has demonstrated knowledge of the principles of growth and development over the life span and possesses the ability to assess data reflective of the patient's status and interpret the appropriate information needed to identify each patient's requirements relative to his/her age specific needs.

Preceptors: Please place a (✓) mark in the appropriate rating column for each competency listed below. Then, sign your full name/credentials on the signature page.

AGES SERVED – CHECK AGE GROUPS SERVED	
☐ A – NEONATES (<30 DAYS)	☐ E – ADULTS (>=18 YEARS & <65 YEARS)
☐ B – INFANTS (>=30 DAYS & 1 YEAR)	☐ F – GERIATRICS (>=65 YEARS)
☐ C – PEDIATRICS (>=1 YEAR & <13 YEARS)	☐ O – NOT APPLICABLE
☐ D – ADOLESCENTS (>=13 YEARS & <18 YEARS)	

PROGRAMS				
☐ AH	☐ BCCCP	☐ CMARC	☐ CH	☐ CD
☐ FP	☐ IM	☐ CMHRP	☐ PHP	☐ PPC
☐ PP/NB	☐ STD	☐ TB	☐ WW	

SKILL	RATING			
Communication	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
1. Employee introduces self and explains/determines purpose of visit.				
2. Employee establishes rapport with client/caregiver.				
3. Employee communicates with client/caregiver in a professional, culturally, and age appropriate manner.				
4. Employee communicates with staff in a professional manner.				
5. Employee provided services confidentially.				
History Taking	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
6. Employee conducts history in accordance with programmatic guidelines.				
7. Employee allows client/caregiver time to explain responses.				
8. Employee allows client/caregiver time to ask questions.				
9. Employee uses leading questions to elicit client information.				
10. Employee provides education and counseling in accordance with programmatic guidelines.				

Counseling	Achieved	Needs Improvement	Not Achieved	Not Applicable
11. Employee provides age appropriate and program specific counseling in a clear, precise and professional manner.				
12. Client verbalized an understanding of information/ counseling provided.				
13. Employee allows client time to ask questions and answers client's questions appropriately.				
Physical Assessment	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
14. Employee explains procedures to client/caregiver.				
15. Employee provides client privacy.				
16. Employee attempts to establish rapport and make client comfortable.				
17. Employee performs components of physical assessment in accordance with programmatic guidelines.				
18. Employee discusses findings with client/caregiver.				
19. Employee makes appropriate referrals based on findings.				
Case Management	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
20. Employee has a system of documenting and follow-up of referrals.				
21. Employee documentation supports all client contacts and referral/follow-up information.				
22. Follow-up is conducted in accordance with agency/ programmatic guidelines.				
23. Records are maintained in accordance with HIPAA guidelines.				
24. Employee documents assessments, counseling and client's information in approved format in accordance with programmatic guidelines.				
25. Documentation is precise and clear.				
26. Handwriting is legible.				
27. Employee uses approved abbreviations.				
28. Employee makes appropriate referrals and follow-up and documentation supports referrals and follow-up.				
Confidentiality	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
29. Employee is aware of and observes all relevant organizational policies and state/federal laws regarding release of confidential medical information.				
30. Employee understands that protection of client confidentiality is NOT limited to the potential for sharing personal medical information outside of the organization, but also includes a prohibition against sharing any of the client's personal information with anyone on the healthcare team or in the healthcare organization who does not have a specific need to know that information.				
Safety	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
31. Employee demonstrates knowledge and implementation of proper body mechanics and OSHA requirements.				
32. Employee demonstrates knowledge of Emergency policies/ protocols.				

Infection Control	Achieved	Needs Improvement	Not Achieved	Not Applicable
33. Employee utilizes standard precautions when working with clients.				
34. Employee demonstrates appropriate hand hygiene.				
Supervision	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
35. Employee recognizes and analyzes problems within program areas and formulates solutions with staff and supervisory collaboration.				
36. Employee provides constructive and timely feedback to interdepartmental agency staff and the community.				
37. Employee keeps direct supervisor informed of departmental decisions and seeks input for decisions when necessary.				
38. Employee anticipates/seeks conflict resolution using chain of command for problem-solving.				
39. Employee fosters team-building by cooperation, communication, and consensus among staff.				
40. Employee ensures effective recruitment, selection, training, performance appraisal, recognition, and corrective/ disciplinary action of staff.				
41. Employee establishes/oversees policies, procedures, guidelines, plans, priorities, resource procurement, and allocation in designated program areas.				
42. Employee actively seeks to improve the quality of service, products, and processes via community/client input.				

Observer/Preceptor Comments:

_____

_____

_____

_____

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_____

Feedback Provided to Employee: **Date:** _____

_____

_____

_____

_____

_____

_____

Follow-Up Planned:

PRN
Other _____

_____

Supervisor's Signature _____ Date _____

Employee's Signature _____ Date _____

Developed: 7/19
Reviewed: 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

The program supervisor should give this information to the Personnel Technician to be stored with HR files.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

ADVANCED PRACTICE PROVIDER SKILLS CHECKLIST

Employee Name: _____

Observer/Preceptor: _____

Date: _____

INITIAL/ANNUAL COMPETENCY VALIDATION CHECKLIST:

The above staff member has demonstrated the knowledge, skills, and attitudes necessary to provide care appropriate to the age of the patients served on his/her assigned unit. The individual has demonstrated knowledge of the principles of growth and development over the life span and possesses the ability to assess data reflective of the patient's status and interpret the appropriate information needed to identify each patient's requirements relative to his/her age specific needs.

Preceptors: Please place a (✓) mark in the appropriate rating column for each competency listed below. Then, sign your full name/credentials on the signature page.

AGES SERVED – CHECK AGE GROUPS SERVED	
☐ A – NEONATES (<30 DAYS)	☐ E – ADULTS (>=18 YEARS & <65 YEARS)
☐ B – INFANTS (>=30 DAYS & 1 YEAR)	☐ F – GERIATRICS (>=65 YEARS)
☐ C – PEDIATRICS (>=1 YEAR & <13 YEARS)	☐ O – NOT APPLICABLE
☐ D – ADOLESCENTS (>=13 YEARS & <18 YEARS)	

PROGRAMS				
☐ AH	☐ BCCCP	☐ CMARC	☐ CH	☐ CD
☐ FP	☐ IM	☐ CMHRP	☐ PHP	☐ PPC
☐ PP/NB	☐ STD	☐ TB		

SKILL	RATING			
Communication	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
1. Employee introduces self and explains/determines purpose of visit.				
2. Employee establishes rapport with client/caregiver.				
3. Employee communicates with client/caregiver in a professional, culturally, and age appropriate manner.				
4. Employee communicates with staff in a professional manner.				
5. Employee provided services confidentially.				
History Taking	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
6. Employee reviews history with client to ensure accuracy and completeness.				
7. Employee allows client/caregiver time to explain responses.				
8. Employee allows client/caregiver time to ask questions.				
9. Employee uses leading questions to elicit client information.				
10. Employee provides education and counseling in accordance with programmatic guidelines.				

Counseling	Achieved	Needs Improvement	Not Achieved	Not Applicable
11. Employee provides age appropriate and program specific counseling in a clear, precise and professional manner.				
12. Client verbalized an understanding of information/ counseling provided.				
13. Employee allows client time to ask questions and answers client's questions appropriately.				
Physical Assessment	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
14. Employee explains procedures to client/caregiver.				
15. Employee provides client privacy.				
16. Employee attempts to establish rapport and make client comfortable.				
17. Employee performs components of physical assessment in accordance with programmatic guidelines.				
18. Employee discusses findings with client/caregiver.				
19. Employee makes appropriate referrals based on findings.				
Medical Practice	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
20. Employee demonstrates appropriate selection of diagnostic testing.				
21. Employee demonstrates appropriate interpretation/analysis of test results.				
22. Employee demonstrates appropriate integration of history and physical findings and diagnostic studies to formulate a differential diagnosis.				
23. Employee demonstrates an overall integration of clinical information into treatment planning.				
24. Employee demonstrates pharmacological knowledge/ appropriate ordering of therapeutics.				
25. Employee accurately records ICD diagnoses and CPT codes for procedures.				
26. Employee demonstrates an understanding of the legal and regulatory requirements governing practice and the role of the advanced practice provider.				
27. Employee practices cost-effective healthcare and resource allocation that does not compromise quality of care.				
28. Employee maintains licensure and meets continuing education requirements.				
Case Management	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
29. Employee has a system of documenting and follow-up of referrals.				
30. Employee documentation supports all client contacts and referral/follow-up information.				
31. Follow-up is conducted in accordance with agency/ programmatic guidelines.				
32. Records are maintained in accordance with HIPAA guidelines.				
33. Employee documents assessments, counseling and client's information in approved format in accordance with programmatic guidelines.				

Case Management (cont.)	Achieved	Needs Improvement	Not Achieved	Not Applicable
34. Documentation is precise and clear.				
35. Handwriting is legible.				
36. Employee uses approved abbreviations.				
37. Employee makes appropriate referrals and follow-up and documentation supports referrals and follow-up.				
Confidentiality	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
38. Employee is aware of and observes all relevant organizational policies and state/federal laws regarding release of confidential medical information.				
39. Employee understands that protection of client confidentiality is NOT limited to the potential for sharing personal medical information outside of the organization, but also includes a prohibition against sharing any of the client's personal information with anyone on the healthcare team or in the healthcare organization who does not have a specific need to know that information.				
Safety	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
40. Employee demonstrates knowledge and implementation of proper body mechanics and OSHA requirements.				
41. Employee demonstrates knowledge of Emergency policies/ protocols.				
Infection Control	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
42. Employee utilizes standard precautions when working with clients.				
43. Employee demonstrates appropriate hand hygiene.				

Observer/Preceptor Comments:

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Feedback Provided to Employee: **Date:** _____

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Follow-Up Planned:

PRN
Other _____

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Supervisor's Signature _____ Date _____

Employee's Signature _____ Date _____

Developed: 7/19
Reviewed: 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

The program supervisor should give this information to the Personnel Technician to be stored with HR files.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

LABORATORY SKILLS CHECKLIST

Employee Name: _____

Observer/Preceptor: _____

Date: _____

INITIAL/ANNUAL COMPETENCY VALIDATION CHECKLIST:

The above staff member has demonstrated the knowledge, skills, and attitudes necessary to provide care appropriate to the age of the patients served on his/her assigned unit. The individual has demonstrated knowledge of the principles of growth and development over the life span and possesses the ability to assess data reflective of the patient's status and interpret the appropriate information needed to identify each patient's requirements relative to his/her age specific needs.

Preceptors: Please place a (✓) mark in the appropriate rating column for each competency listed below. Then, sign your full name/credentials on the signature page.

AGES SERVED – CHECK AGE GROUPS SERVED	
☐ A – NEONATES (<30 DAYS)	☐ E – ADULTS (>=18 YEARS & <65 YEARS)
☐ B – INFANTS (>=30 DAYS & 1 YEAR)	☐ F – GERIATRICS (>=65 YEARS)
☐ C – PEDIATRICS (>=1 YEAR & <13 YEARS)	☐ O – NOT APPLICABLE
☐ D – ADOLESCENTS (>=13 YEARS & <18 YEARS)	

PROGRAMS				
☐ AH	☐ BCCCP	☐ CMARC	☐ CH	☐ CD
☐ FP	☐ IM	☐ CMHRP	☐ PHP	☐ PPC
☐ PP/NB	☐ STD	☐ TB		

SKILL	RATING			
Communication	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
1. Employee introduces self and explains/determines purpose of lab visit.				
2. Employee establishes rapport with client/caregiver.				
3. Employee communicates with client/caregiver in a professional, culturally, and age appropriate manner.				
4. Employee communicates with staff in a professional manner.				
5. Employee provided services confidentially.				
Preparation	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
6. Employee verifies identity of client with two unique identifiers.				
7. Employee verifies all ordered lab tests and ensures correct client is receiving the correct tests.				
8. Employee inquires about client's specimen collection history and requirements including questions related to past blood draws (e.g. difficult stick), site preference (e.g. mastectomy, fistula, etc.) latex allergies, and any previous adverse experiences with blood draws (e.g. fainting).				

Procedure	Achieved	Needs Improvement	Not Achieved	Not Applicable
9. Employee demonstrates knowledge of all equipment and materials used in the laboratory.				
10. Employee demonstrates proper procedure for venipuncture, fingerstick, and heelstick.				
11. Employee demonstrates proper procedure for all laboratory tests performed in-house and proper collection/packaging of samples sent to off-site laboratories.				
12. Employee can locate/use most current Technical Laboratory Manual and SDS Manual.				
Documentation	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
13. Documentation is precise and clear.				
14. Handwriting is legible.				
15. Employee uses approved abbreviations.				
16. Employee completes all log entries for the day, using a double-check system.				
Situations	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
17. Employee responds appropriately to client crisis and stops collection if warranted (e.g. nausea, fainting, etc.)				
18. Employee responds appropriately to stressful/challenging situations (e.g. difficult clients, combative clients).				
19. Employee responds appropriately when unable to obtain blood.				
Confidentiality	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
20. Employee is aware of and observes all relevant organizational policies and state/federal laws regarding release of confidential medical information.				
21. Employee understands that protection of client confidentiality is NOT limited to the potential for sharing personal medical information outside of the organization, but also includes a prohibition against sharing any of the client's personal information with anyone on the healthcare team or in the healthcare organization who does not have a specific need to know that information.				
Safety	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
22. Employee demonstrates knowledge and implementation of proper body mechanics and OSHA requirements.				
23. Employee demonstrates knowledge of Emergency policies/ protocols.				
Infection Control	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
24. Employee utilizes standard precautions when working with clients.				
25. Employee demonstrates appropriate hand hygiene.				
26. Employee properly disposes of all biological waste and sharps.				
Lab Manager	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
27. Employee completes all meetings, policies, procedures, contracts, and manuals required by the NSLPH, State Lab consultant, and RCHHS.				

28. Employee investigates and approves all outside laboratory bills.				
29. Employee ensures all laboratory equipment is calibrated and undergoes annual maintenance.				
30. Employee maintains appropriate inventory of laboratory supplies.				

Observer/Preceptor Comments:

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Feedback Provided to Employee: **Date:** _____

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Follow-Up Planned:

PRN
Other _____

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Supervisor's Signature _____ Date _____

Employee's Signature _____ Date _____

Developed: 7/19
Reviewed: 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

The program supervisor should give this information to the Personnel Technician to be stored with HR files.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

INTERPRETER SKILLS CHECKLIST

Employee Name: _____

Observer/Preceptor: _____

Date: _____

INITIAL/ANNUAL COMPETENCY VALIDATION CHECKLIST:

The above staff member has demonstrated the knowledge, skills, and attitudes necessary to provide care appropriate to the age of the patients served on his/her assigned unit. The individual has demonstrated knowledge of the principles of growth and development over the life span and possesses the ability to assess data reflective of the patient's status and interpret the appropriate information needed to identify each patient's requirements relative to his/her age specific needs.

Preceptors: Please place a (✓) mark in the appropriate rating column for each competency listed below. Then, sign your full name/credentials on the signature page.

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☐ C – PEDIATRICS (>=1 YEAR & <13 YEARS)	☐ O – NOT APPLICABLE
☐ D – ADOLESCENTS (>=13 YEARS & <18 YEARS)	

PROGRAMS				
☐ AH	☐ BCCCP	☐ CMARC	☐ CH	☐ CD
☐ FP	☐ IM	☐ CMHRP	☐ PHP	☐ PPC
☐ PP/NB	☐ STD	☐ TB		

SKILL	RATING			
Introduction/Role of the Interpreter	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
1. Employee introduces self and explains role of interpreter to client, and establishes rapport with client.				
2. Employee encourages client to ask for clarification of any issue as it arises during the visit.				
3. Employee relays to the client legal requirements and essential information regarding informed consent, confidentiality, and security of medical communication.				
4. Employee asks the provider to introduce him/herself to the client using his/her full title to explain/determine purpose of the visit.				
Cultural Understanding	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
5. Employee understands the rules of cultural etiquette with respect to status, age, gender, hierarchy, potential barriers to communication, and level of acculturation.				
6. Employee shares any relevant cultural information with both client and provider to facilitate understanding between all parties.				

Interpretation Skills	Achieved	Needs Improvement	Not Achieved	Not Applicable
7. Employee understands the vital role of accurate interpretation and understands the risks of inaccurate interpretation in a medical situation.				
8. Employee ensures that he/she understands the message prior to transmission.				
9. Employee understands his/her limitations of medical knowledge, refrains from making assumptions, and demonstrates willingness to obtain clarification of medical terms and concepts as necessary.				
10. Employee ensures that the listener (client/family) understands what is being conveyed after transmission of the information.				
Communication Skills	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
11. Employee is cognizant of the changing tone and emotional content of medical conversations, and remains alert to internal conflicts that may emerge between provider and client.				
12. When strong feelings or conflict arise between the provider and the client, the interpreter does not take sides in the conflict and remains calm while acknowledging the tension between the client and provider. Employee manages the situation effectively through use of clarification.				
13. Employee manages his/her own internal personal conflicts by clearly separating his/her own values and beliefs from those of the client and provider of care.				
Role of Facilitator	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
14. Employee makes certain that the client understands the clinical instructions provided and what he/she must do next.				
15. Employee explains after hours process to clients with limited English proficiency.				
16. Employee ensures that any concerns raised during the clinical visit are addressed and referred to clinical personnel who can assist with resolution of such concerns.				
Clinical Tasks	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
17. Employee completes appropriate documentation as indicated or requested by clinical personnel.				
18. Employee assists nurse and/or provider to collect client specimen(s) and transports to laboratory personnel per protocol.				
19. Employee follows policy and protocol in the cleaning/ disinfection/autoclaving of medical instruments.				
Confidentiality	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
20. Employee is aware of and observes all relevant organizational policies and state/federal laws regarding release of confidential medical information.				
21. Employee understands that protection of client confidentiality is NOT limited to the potential for sharing personal medical information outside of the organization, but also includes a prohibition against sharing any of the				

client's personal information with anyone on the healthcare team or in the healthcare organization who does not have a specific need to know that information.				
Impartiality	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
22. Employee is aware and able to identify any personal bias, belief, or conflict of interest that may interfere with his/her ability to impartially interpret in any given situation, and discloses this to the provider so that another interpreter can step in to provide the service.				
Professional Distance	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
23. Employee does not create any expectations that the interpreter role cannot fulfill.				
24. Employee actively promotes patient self-sufficiency.				
Safety	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
25. Employee demonstrates knowledge and implementation of proper body mechanics and OSHA requirements.				
26. Employee demonstrates knowledge of Emergency policies/ protocols.				
Infection Control	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
27. Employee utilizes standard precautions when working with clients.				
28. Employee demonstrates appropriate hand hygiene.				

Observer/Preceptor Comments:

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Feedback Provided to Employee: **Date:** _____

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Follow-Up Planned:

PRN
Other _____

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Supervisor's Signature _____ Date _____

Employee's Signature _____ Date _____

Developed: 7/19
Reviewed: 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

The program supervisor should give this information to the Personnel Technician to be stored with HR files.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

FAMILY CARE COORDINATION CARE MANAGER
SKILLS CHECKLIST

Employee Name: _____

Observer/Preceptor: _____

Date: _____

INITIAL/ANNUAL COMPETENCY VALIDATION CHECKLIST:

The above staff member has demonstrated the knowledge, skills, and attitudes necessary to provide care appropriate to the age of the patients served on his/her assigned unit. The individual has demonstrated knowledge of the principles of growth and development over the life span and possesses the ability to assess data reflective of the patient's status and interpret the appropriate information needed to identify each patient's requirements relative to his/her age specific needs.

Preceptors: Please place a (✓) mark in the appropriate rating column for each competency listed below. Then, sign your full name/credentials on the signature page.

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☐ C – PEDIATRICS (>=1 YEAR & <13 YEARS)	☐ O – NOT APPLICABLE

PROGRAMS	
☐ CMHRP	☐ CMARC

SKILL	RATING			
Communication	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
1. Employee introduces self and explains/determines purpose of visit.				
2. Employee establishes rapport with client/caregiver.				
3. Employee communicates with client/caregiver in a professional, culturally, and age appropriate manner.				
4. Employee communicates with staff in a professional manner.				
5. Employee provided services confidentially.				
History Taking	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
6. Employee conducts history in accordance with programmatic guidelines.				
7. Employee allows client/caregiver time to explain responses.				
8. Employee allows client/caregiver time to ask questions.				
9. Employee uses leading questions to elicit client information.				
10. Employee provides education and counseling in accordance with programmatic guidelines.				

Counseling	Achieved	Needs Improvement	Not Achieved	Not Applicable
11. Employee provides age appropriate and program specific counseling in a clear, precise and professional manner.				
12. Client verbalized an understanding of information/ counseling provided.				
13. Employee allows client time to ask questions and answers client's questions appropriately.				
Physical Assessment	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
14. Employee explains procedures to client/caregiver.				
15. Employee provides client privacy.				
16. Employee attempts to establish rapport and make client comfortable.				
17. Employee performs components of physical assessment in accordance with programmatic guidelines.				
18. Employee discusses findings with client/caregiver.				
19. Employee makes appropriate referrals based on findings.				
Case Management	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
20. Employee has a system of documenting and follow-up of referrals.				
21. Employee documentation supports all client contacts and referral/follow-up information.				
22. Follow-up is conducted in accordance with agency/ programmatic guidelines.				
23. Records are maintained in accordance with HIPAA guidelines.				
24. Employee documents assessments, counseling and client's information in approved format in accordance with programmatic guidelines.				
25. Documentation is precise and clear.				
26. All documentation is entered in approved EHR.				
27. Employee uses approved abbreviations.				
28. Employee makes appropriate referrals and follow-up and documentation supports referrals and follow-up.				
Confidentiality	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
29. Employee is aware of and observes all relevant organizational policies and state/federal laws regarding release of confidential medical information.				
30. Employee understands that protection of client confidentiality is NOT limited to the potential for sharing personal medical information outside of the organization, but also includes a prohibition against sharing any of the client's personal information with anyone on the healthcare team or in the healthcare organization who does not have a specific need to know that information.				
Safety	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
31. Employee demonstrates knowledge and implementation of proper body mechanics and OSHA requirements.				
32. Employee demonstrates knowledge of Emergency policies/ protocols.				

Infection Control	Achieved	Needs Improvement	Not Achieved	Not Applicable
33. Employee utilizes standard precautions when working with clients.				
34. Employee demonstrates appropriate hand hygiene.				
Supervision	**Achieved**	**Needs Improvement**	**Not Achieved**	**Not Applicable**
35. Employee recognizes and analyzes problems within program areas and formulates solutions with staff and supervisory collaboration.				
36. Employee provides constructive and timely feedback to interdepartmental agency staff and the community.				
37. Employee keeps direct supervisor informed of departmental decisions and seeks input for decisions when necessary.				
38. Employee anticipates/seeks conflict resolution using chain of command for problem-solving.				
39. Employee fosters team-building by cooperation, communication, and consensus among staff.				
40. Employee ensures effective recruitment, selection, training, performance appraisal, recognition, and corrective/ disciplinary action of staff.				
41. Employee establishes/oversees policies, procedures, guidelines, plans, priorities, resource procurement, and allocation in designated program areas.				
42. Employee actively seeks to improve the quality of service, products, and processes via community/client input.				

Observer/Preceptor Comments:

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Feedback Provided to Employee: **Date:** _____

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Follow-Up Planned:

PRN
Other _____

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Supervisor's Signature _____ Date _____

Employee's Signature _____ Date _____

Developed: 7/19
Reviewed: 6/20; 6/21; 6/22; 6/23; 6/24
Revised:

The program supervisor should give this information to the Personnel Technician to be stored with HR files.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

PEDIATRIC PRIMARY CARE POLICIES

SECTION	POLICY NO.
Pediatric Primary Care Program	PPC-1

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PEDIATRIC PRIMARY CARE

DATE DEVELOPED: 9/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/22; 6/23; 6/24

I. POLICY:

The Division of Public Health Services will provide services to all children up to age 21 that reside in Rockingham County.

II. PURPOSE:

It is the intent of this program to offer services to children up to the age of 21. Services are intended to reduce mortality and morbidity among children and youth resulting from communicable diseases, injuries, and other preventable conditions and promote healthy behaviors which support optimal physical, social, and emotional health of children. These services are considered primary care or sick visits.

III. GUIDELINES:

A. The hours of operation are 8:00 am – 5:00 pm Monday through Friday, and 8:00 am – 7:00 pm on **most Thursdays**. The EHR Communicator Application will remind clients of their appointments prior to the appointment date via text message or automated phone call.

B. The Pediatric Primary Care Program will promote customer friendly services that meet the needs of populations that are underserved.

C. No person, on the grounds of color, race, creed, age, religion, sex, sexual orientation, political affiliation, physical handicap, or national origin will be denied services or benefits. All educational materials are given on a literacy level appropriate for the client.

D. Scheduling – Appointments are generally scheduled; however, in a case of acute illness, the child may be worked into the daily schedule.

E. Physical assessments are provided by the Advanced Practice Providers (APPs) and the child health nurse screeners. Subsequent physicals and treatment visits are provided by the APP and the child health screeners according to protocols under the standing orders.

1. a. As appropriate for the visit, the child health nurse will first fill out basic information on the Bright Futures Form in the electronic health record (EHR), and perform and accurately record appropriate procedures as follows:

- Height
- Weight
- Respirations
- Temperature
- Blood Pressure
- Head Circumference
- Developmental Screening & Autism Screening
- Vision Screening
- Hearing Screening
- Basic Nutritional Assessment and Referral

b. The nurse or APP will complete all sections of the visit within the EHR. On the physical examination it will be indicated if within normal limits. If it is not within normal limits a further explanation will be documented.

c. The 5A method for tobacco cessation will be provided for all Pediatric Primary Care (PPC) clients and their family as recommended and a referral made to the appropriate community resource, NC Tobacco Use Quit Line @ 1-800-QUIT NOW or 1-800-784-8669, if needed. This teaching will be used to impact the exposure to second hand smoke on young children and the increasing incidence of asthma and SIDS.

d. Child will be screened by BMI for risk of dyslipidemia with referral and follow-up as needed. Perform risk assessment at 2, 4, 6, and 8 years of age and then at each annual visit.

2. For Pediatric Primary Care visits the following services will be provided:

a. Medical history for each problem that includes:

- Condition prior to onset
- Description of symptoms including onset, current status, and effect of any therapy and/or home remedy
- Review of systems pertinent to the problem, and
- Immunization history and assessment of immunization status with referral or administration of vaccine if needed.

b. Physical examination for each problem which includes:

- Examination of body system(s) related to the chief complaint
- Blood pressure for children over 3 years of age; and
- Laboratory testing as indicated by the presenting problem and assessment.

c. Recorded diagnosis for each problem identified

d. Referral and/or follow up as indicated

e. Education/counseling concerning each problem identified
f. Referral or follow up appointment of routine well child services for those children seen for other services.

3. The APP performs a variety of functions in the area of pediatrics that involves making independent judgments in the primary health care of pediatric clients and their families. The APP performs primary health care as listed and must be documented in the medical record:

a. All infants up to 6 weeks of age presenting to the Pediatric Primary Care Clinic will be screened to determine if the mother was positive for Group Beta Streptococcus during the pregnancy. The PHN will verify that the mother received appropriate treatment intrapartally. If the mother is unable to relate this information, the PHN will contact the delivering hospital for this information.
b. Performs comprehensive pediatric appraisal including physical examination and developmental evaluation on all children, birth through adolescence, as it relates to the chief complaint for each problem which will include:

- examination of body systems related to chief complaint
- a blood pressure for children over 3 years of age
- lab testing as indicated by the presenting problem and assessment
- a recorded diagnosis for each problem identified
- educates/counsels regarding each problem identified
- referral as indicated
- children seen for other than well-child visits will receive a referral for routine well child visit, or receive a follow-up appointment for a routine well-child visit

Services must be documented on all individuals receiving pediatric primary care in the local health department. Referrals and follow-up appointments are made for routine well child services for children referred to pediatric primary care from other health department programs.

Components of the well child care visits will be performed and documented according to the Child Health Policy (CH-1).

F. <u>Lab and Other Diagnostic Services</u>

The Primary Care Program will be able to provide the following lab and diagnostic procedures: hemoglobin, urinalysis, blood lead level, hemoglobin electrophoresis, PKU, throat culture, blood sugar, serologies, parasitology, and EKG or any other lab deemed necessary by the APP.

Other laboratory procedures not within the scope of the primary care facility will be handled on a referral basis to a private referral lab. These procedures include such things as hematology, blood chemistry, culture and sensitivities. The client will have primary responsibility for payment of diagnostic procedures obtained at the local hospital or referral laboratories. X-rays will be referred to a local hospital.

G. Follow-Up

1. The APP will schedule return appointments as appropriate for on-going follow-up of all clients. Clients may remain within the Primary Care System for their medical care until they withdraw from the program by their choice. The APP may encourage those clients exceeding 21 years of age to seek general medical care in the Adult Primary Care Clinic.

2. Clients are reminded of their return appointments by the EHR Communicator Application via text message or automated phone call.

H. Referral and Documentation

If the Division of Public Health Services makes a referral for an outside medical provider, we will notify the client of the scheduled appointment date and time.

1. Children seen for Pediatric Primary Care services will receive a referral for a routine well child visit or well follow-up appointment for a routine well child visit.

2. Clients referred to the supervising physicians or medical consultants will have the appropriate referral information and documentation sent to the referring providers.

3. Referrals may be made by the APP after the medical evaluation and upon consultation.

4. Referral channels are established between the Primary Care Program and private medical resources available to the community, including local physicians and hospitals. Other referral channels will be utilized that are currently available to ongoing health department programs. As much as possible, referrals will be based on choice of clients and their families.

I. Primary Care Advanced Practice Provider

The Primary Care APP will provide services under the supervision and direction of the medical consultants. The medical consultants are contacted

for back-up services as needed. The protocols for the Primary Care Clinic are reviewed and updated annually.

1. Collaborative physician will review and cosign selected medical records per collaborative agreement.

2. In the absence of the APP in the Primary Care Clinic, the supervising physician will be notified if services are needed for a client presenting with symptoms that extend beyond the scope of practice of the RN.

J. Improving Organization Performance

1. State and local reports and statistics are reviewed at least annually to determine if the needs of the community are being met and changes made if indicated.

2. The Pediatric Primary Care Clinic Program and charts will be audited quarterly.

   a. A minimum of 12 client records (4 from each month of the quarter) will be reviewed.
   b. The purpose of the chart audit will be to:

      (1) Ensure that the level of medical care specified by state guidelines, Child Health Policies, and procedures and protocols of the specified programs are being met.
      (2) Discuss problems in clinic and Child Health Program and make recommendations to correct deficiencies found and other improvements.
      (3) The client record selection will be based on a computer printout of the program and quarter in review. The charts will be randomly selected for the printout. The state audit forms will be used.
      (4) The results of the audit will be tabulated and recorded. Information discussed within the report will have the client medical record number, rather than any other identifying information.
      (5) All members of the program team will be informed of the results of the audit. The strengths and weaknesses will be identified and summarized along with a corrective plan of action.

3. The health department will report any interruption in service or ability to meet quality assurance deliverables within 14 days to the Regional Child Health Nurse Consultant. The agency will update changes in contact information for the Program Coordinator/

Program Supervisor within two weeks of change. The change will be provided to the State Regional Child Health Nurse Consultant.

K. Client Satisfaction Surveys

The Pediatric Primary Care Program will distribute client satisfaction surveys on a monthly basis. The results will be compiled and a report of the findings will be generated among staff monthly. Areas for improvement will be addressed monthly on an on-going basis.

L. Staff Qualifications

1. The agency will ensure training of all child health staff and implementation of evidence based health literacy strategies in child health clinics to assure parents and clients can read, understand, and apply health information to make health decisions to improve health outcomes. This will be accomplished through annual staff training, workshops, during orientation, and annually with review of policies.

2. The agency will increase staff awareness of disparities in health status and service delivery, especially disparities related to race/ ethnicity, disability, and socioeconomic status. This will be accomplished through annual staff training, workshops, during orientation, and annually with review of policies. Annual review of child health outcomes and related trends for the county and state to identify major opportunities and improve outcomes and decrease disparities in the county. The following state and county level data sources are available on the **NC State Center for Health Statistics website https://schs.dph.ncdhhs.gov/data**.

    a. Child Health Assessment and Monitoring Program (CHAMP)
    b. **County Health Data Book**
    c. **Behavioral Risk Factor Surveillance System (BRFSS)**
    d. **North Carolina Statewide and County Trends in Key Health Indicators**

3. All nurses serving children who receive designated preventative services have received special Child Health Enhanced Role Training and are currently rostered with the Office of Public Health Nursing and Professional Development. The agency maintains records for all rostered Child Health Enhanced Role Nurses to include confirmation of current rostered status and log of continuing education hours and clinical hours performing EPDST screening examinations.

M. Back-up Services

Back-up services for PPC will be as follows:

1. If available at the Division of Public Health Services, a substitute or contract APP will see clients.

2. If no APP is available, the local urgent care or emergency department of a local hospital.

3. Referral to Dayspring Family Medicine.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

PHARMACY INDEX

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SCOPE OF PHARMACY SERVICES

DATE PREPARED: 6/87
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 8/01; 6/12; 6/14

These policies are set up to enable this department to:

1. Provide the maximum benefits and services to the citizens of Rockingham County.

2. Allow for the most efficient delivery of prescription services.

3. Insure the integrity of drug supplies and records.

4. Insure that all dispensing is in compliance with the Rules and Regulations of the North Carolina Department of Health and Human Services and the North Carolina Board of Pharmacy and comply with all state and federal laws.

5. Stress quality assurance and error prevention in all training and program guidelines.

6. Solicit input from Division of Public Health Services staff, appropriate county and state organizations, and clientele of the department.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PHARMACY CLINICAL SERVICES

DATE PREPARED: 4/96
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 3/10; 6/12; 6/14; 6/17; 6/18

I. POLICY:

The Division of Public Health Services Pharmacy will serve clients who are eligible for services including Prescription Assistance Programs.

II. PURPOSE:

1. To provide a means for dispensing medications and devices from a limited formulary, samples, or assistance programs to be used for the treatment of clients receiving care in Women's Preventive Health Services, Family Planning and Sexually Transmitted Disease Services, Pediatric Primary Care Services, Adult Health Services, Communicable Disease, Prescription Assistance, and Dental Clinic.

2. To offer pharmacist counseling services on all new medication orders with proper documentation.

3. To provide pharmacist medication management services for our Patient Assistance Program clients through therapeutic substitutions, polypharmacy and adverse drug review, and disease state-medication availability recommendations.

4. To provide providers and other health professionals in the agency, upon request, clinical drug information.

III. GUIDELINES:

A. Pharmacy hours are Monday through Thursday from 9:00 am - 5:00 pm. Provisions will be made for night clinics as necessary.

   1. The Pharmacist will dispense medications and devices as ordered according to the formulary.

   2. Physician Extenders and Registered Nurses that have completed the Dispensing of Drugs by Public Health Nurses course may dispense medications and devices according to their specific program guidelines. The medications dispensed by nursing and physician extenders will only be within their specific program.

B. The pharmaceutical services may be required after the client has been seen in the medical clinics of the Division of Public Health Services, only. However, this does not include services provided by the Prescription Assistance Programs.

C. The prescriptions written by the Division of Public Health Services Providers are the only prescriptions filled for health department clients. The following exceptions may occur: prescriptions from outside specialists for which our providers referred Community Prescription Assistance Program (CPAP), patient prescriptions, Communicable Disease prescriptions, and employee prescriptions as needed. Prescriptions written during Glaucoma Clinic at the Division of Public Health Services are obtained through the assistance programs.

D. The following may occur if clients cannot afford the co-pay for prescriptions in the Pharmacy:

1. If the client voices his/her inability to purchase the needed medication and devices he/she should be asked if they have any other resource. (It should not be assumed that the client cannot pay for medications.)

2. If there is no known resource available the client may be given the first prescription from the pharmacy.

3. The client should be told that he/she will need to find another resource for future medications and devices. If client is on chronic medications, then a referral source will be sought.

4. A referral from the client's provider may be made into the Prescription Assistance Program (PAP). Clients will be screened for eligibility for receiving medications.

E. Prescribing: Each physician extender will be given an approved updated pharmacy formulary every year. The formulary must be in compliance with the Board of Pharmacy, the Board of Nursing, and the Board of Medical Examiners. There is a formulary subcommittee comprised of providers and pharmacists to keep the formulary limited, to minimize costs but complete, to offer the essential needed medications. This committee should meet at least once a year. The providers may make formulary requests when certain medications are needed. These requests can be verbalized to a pharmacist who in return must notify all providers in writing, of additions to the formulary. Formulary changes do not have to be approved by the P&T Committee unless unusual circumstances result.

F. Pharmacy Formulary: A limited pharmacy formulary will be kept for inventory management. This formulary will be comprised of the most useful and cost effective drugs for the treatment of illnesses common in adults and children. The pharmacy will have sample medications that will vary from week to week. These are available at no charge to health department clients.

1. All the medications and devices listed in the Pharmacy Formulary should be stocked in the pharmacy according to availability.

2. Staff should order those medications and devices listed on the pharmacy formulary, if possible.

3. If a non-formulary drug is ordered, a prescription may be given to a client to carry to an outside pharmacy for filling.

G. Dispensing -

1. Division of Public Health Services Pharmacy dispenses medications according to the following expectations:

   a. Provides proper labeling, packaging, and filling of medications.
   b. Provides side effects, allergy and drug interaction checks for medications filled.
   c. Maintains record keeping requirements.
   d. Provides a safe and clean environment for drug dispensing.

2. All drugs dispensed at the Pharmacy by a nurse practitioner or physician assistant shall be retrospectively reviewed by a pharmacist within 7 days. The reviewing pharmacist may advise and consult with the dispensing nurse practitioner, physician assistant, or supervising physician about potential drug therapy concerns which may result from:

   a. therapeutic duplication;
   b. drug-disease contraindication;
   c. drug interactions;
   d. incorrect drug dosage or duration of drug treatment; and
   e. interactions between drugs and allergies.

3. A written order for medications and devices must be presented. The dispensing of a prescription drug without a valid prescription order is unlawful.

4. Prescriptions in the pharmacy shall be dispensed by the pharmacist on duty.

5. The Pharmacy will not dispense medication without a valid prescription order. Furthermore, clients who seek OTC medications must have a prescription order from our providers before receiving these medications at the pharmacy. Diabetic supplies or supplies through grant funding are exceptions.

6. Dispensing by Registered Nurse, Nurse Practitioner or Physician's Assistant:

   a. The physician extenders may dispense any and all drugs that the extender is authorized by law to prescribe. The pharmacist routinely provides the dispensing on a daily basis, however the physician extender may choose to fill prescriptions in an emergency situation. If not an emergency the physician extender will use their discretion to refer client to pharmacist for assistance.
   b. The pharmacist will prepare a plan to ensure there are adequate amounts of the drugs dispensed by the nurse practitioner or physician assistant, and that such drugs are properly stored and packaged.
   c. The consulting pharmacist shall be available for consultation in person, by telephone, or other means of direct communication at all times when drugs are dispensed. Emergency phone number is listed in the pharmacy.
   d. All drugs dispensed by the Physician Extender shall be pre-packaged in safety closure containers and pre-labeled by the pharmacist with all information required by law except the name of the client and directions for use.
   e. The name of the client and directions for use will be placed on the label by the Physician Extender at the time it is delivered to the client or representative.
   f. All medications and devices dispensed by the nurse practitioner or physician assistant will be retrospectively reviewed by the pharmacist within 7 days. The pharmacist may advise or consult the dispensing nurse practitioner or physician assistant about any potential drug therapy concerns.
   g. Registered Nurses employed by the Division of Public Health Services may dispense prescription drugs or devices under the following conditions:

      - Drugs or devices may be dispensed only to health department clients;
      - Registered Nurses may only dispense within their respective clinic;

- Only the general categories of drugs or devices listed in Rule .2403 may be dispensed by a health department Registered Nurse (as listed in the NC Board of Pharmacy Rules and Regulations).

  (1) Anti-tuberculosis drugs as recommended by the Tuberculosis Control Branch of the North Carolina Division of Health Services, when used for the treatment and control of tuberculosis;
  (2) Anti-infective agents used in the control of sexually-transmitted diseases as recommended by the United States Centers for Disease Control;
  (3) Natural or synthetic hormones and contraceptive devices when used for the prevention of pregnancy;
  (4) Topical preparations for the treatment of lice, scabies, impetigo, diaper rash, vaginitis, and related skin conditions; and
  (5) Vitamin and mineral supplements.

- All drugs or devices dispensed shall be packaged in suitable safety-closure containers, where appropriate, and shall be properly labeled (including necessary auxiliary labels) so as to provide information necessary for use and all other information required by state and federal law;
- A suitable and perpetual record of drugs or devices dispensed shall be maintained in pharmacy. The pharmacist shall verify the accuracy of the records within 7 days.

h. <u>Training of Division of Public Health Services Nurses</u>: Training for Registered Nurses to dispense medications at the Division of Public Health Services Pharmacy will be conducted onsite. The Pharmacist will teach Registered Nurses who are not already certified using a North Carolina Board of Pharmacy approved training model. This model involves both testing and hands on training in the Pharmacy. After completion of training, nurses will receive a certification for the course work.

i. Relationship between the Pharmacist, Public Health Nurse and Division of Public Health Services Administration:

- Role of the Pharmacist-Manager

- assure drug control and accountability
- serve as a source of drug information
- assure compliance with laws and rules
- assist in training public health nurses
- verify accuracy of pharmacy records
- update PHN on new dispensing rules
- provide guidance, support and feedback to problems

- Role of Public Health Nurse
  - comply with control and accountability system
  - inform pharmacist-manager of problems
  - remain current with information necessary to dispense
  - assist in training PHN for dispensing

7. In the absence of the pharmacist, or in the event of a prescription back log, RN's trained to dispense or nurse practitioners and PA's trained to dispense may dispense drugs on their formulary to clients in their clinic.

8. In the absence of the pharmacist, the pharmacy technician may give refills of a medication to a client that has already been filled by the pharmacist. If the medication filled was for a new prescription, the technician must inform the client if they have questions, they can talk to the pharmacist via telephone for information regarding the new prescription. Emergency contact information for the pharmacist will be located in the pharmacy if the pharmacist is not on site.

9. Original prescriptions and refill records are to be kept for a period of three years.

10. Controlled substance prescriptions must be kept for 5 years. However, at this time there are no controlled substances present.

11. Compounding Prescriptions -

    a. Provider prescriptions from the Division of Public Health Services clinics and certain floor stock preparations may be prepared by the pharmacist, student pharmacist, or registered pharmacy technician (under the direct supervision of the pharmacist).
    b. Compounded floor stock preparations will be available based on time permitted, availability of ingredients and equipment permits.
    c. Prescriptions will be compounded and recorded in the "Compounding Log" according to the rules and regulations

of the Board of Pharmacy. With the exception of the simple reconstitution of drug products, the pharmacy shall maintain a log showing the name or initials of the person who compounded a drug product and the name or initials of the pharmacist who checked the compounded drug product. The necessary information for each compounded prescription will be recorded.

d. Preparations will be sent to a local drug store for compounding if not available in our Pharmacy.

e. All compounding equipment and utensils shall be cleaned and sanitized with hot soapy water and rinsed well prior to use and after use. Pharmacists shall have written procedures and formulas for the compounding of drug products.

f. With the exception of the simple reconstitution of drug products, all pharmacy records resulting from compounding including the Compounding Log shall be readily retrievable and maintained in the Pharmacy for a period of three years.

12. PHARMACISTS' RIGHT TO REFUSE A PRESCRIPTION

a. A pharmacist may refuse to fill or refill a prescription order if, in his professional judgment, it would be harmful to the recipient, is not in the recipient's best interest or if there is a question as to its validity.

b. A pharmacist shall not fill or refill a prescription order if the pharmacist actually knows or reasonably should know that the order was issued without a physical examination of the patient and in the absence of a prior prescriber-patient relationship.

H. <u>Packaging:</u>

1. Prescriptions will be packaged in a child-resistant container when appropriate. Packaging must adhere to the requirements of the Poison Prevention Packaging Act of 1970.

2. The prescriber or consumer may request that non-safety closures be used. When this occurs, the pharmacist should have the client sign a release form.

3. When refilling a prescription, it is the obligation of the dispenser to determine if the container meets the requirements listed above. These requirements also apply to pre-packaged drugs. In the case of birth control pills, packages as provided by the manufacturer constitute child resistant containers.

I. Substitution:

1. The Pharmacist may dispense an A.B. Rated generic equivalent of any medication ordered by its trade name if the provider signs substitution permitted.

2. In addition to generic substitution, the Pharmacy and Therapeutics Committee has approved therapeutic substitutions of certain products (see Therapeutic Substitution Policy).

3. When an order is written for one of these medications, the approved therapeutic equivalent shown will be dispensed, unless the physician extender writes "No Substitution" on the order.

4. There will be "No" substitution on narrow-range therapeutic medications (e.g. Lanoxin, Coumadin, etc.).

J. Counseling:

1. Client counseling is the effective communication of directions and information to the client or representative to ensure the proper use of the prescribed medication or device.

2. The following information should be discussed as part of the client counseling:

   a. name, description, and purpose of the medication or device;
   b. route, dosage, administration, and continuity of therapy;
   c. special directions for use by the client;
   d. common severe side effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
   e. techniques for self-monitoring drug therapy;
   f. proper storage;
   g. prescription refill information; and
   h. action to be taken in the event of a missed dose

3. An offer to counsel will be made on new or transfer prescriptions for all clients at the time the prescription is dispensed to the client or their representative. Permission must be obtained from client for representative to pick up and receive instructions on prescriptions.

4. The pharmacist is responsible for ensuring that all personnel conducting counseling (i.e., pharmacy students) are proficient in explaining and demonstrating the safe and proper use of medications and devices and also for documenting the demonstration of client understanding.

5. Counseling may be completed orally in the pharmacy or clinical setting, or through telephone communication.

6. An offer to counsel will be communicated in a positive manner to encourage acceptance.

7. Effective counseling will be obtained, recorded, and maintained through documentation which may include, but not limited to the following information:

   a. name, address, telephone number;
   b. date of birth (age), gender;
   c. medical history:
      - disease state
      - allergies/drug reactions
      - current list of non-prescription and prescription medications, devices
   d. pharmacist comments relevant to the individual's drug therapy

8. The patient will sign the needed documentation which includes:

   - prescription number
   - date filled
   - drug strength
   - drug amount, and
   - if patient received counseling

   This information is kept in the pharmacy.

9. Records including documentation of refusals to receive counseling will be maintained for one year.

K. <u>Medication Errors:</u>

1. A medication error is defined as any of the following:

   a. Medication given that should not have been given (incorrect drug or incorrect client)
   b. Incorrect dose – either too large or too small
   c. Incorrect route of administration
   d. Labeled incorrectly

2. All medication errors are to be reported to the prescribing physician extender.

3. The pharmacy error is to be documented on the Incident Report Form by the Pharmacist Manager. This form is to be given to the

Staff Development Coordinator. The Pharmacy Manager will discuss all pharmacy errors with the appropriate pharmacy personnel. The Incident Report Forms will be filed in the Pharmacy.

4. An error resulting in death or serious harm will be investigated on a Sentinel Event and reported to the Board of Pharmacy.

L. Investigational Drugs: The Division of Public Health Services will not obtain, store or dispense any type of investigational medication or device.

M. Adverse Drug Reaction: A Provider must fill out an Adverse Drug Reaction form, if a patient experiences an anaphylactic reaction or has a possible hospital admission due to medication. This form must be submitted to the Staff Development coordinator and in return submitted to the Clinical Pharmacist for P & T review.

N. Drug Samples: In the interest of effective control, the distribution of medication and device samples within the health department will be limited. Any sample medications or devices brought into the agency shall be controlled through the pharmacy.

O. Multi-Dose Vials: There are a few multi-dose vials stocked in various areas of the agency. When opened, MDV's must have the date opened, date written, and nurse's initials and are to be discarded and stored as documented on the manufacturer's package insert.

P. Refills: Refills are "NOT" to be automatically supplied (with the exception of oral contraceptives. It is at the discretion of the provider to give refills on chronic medications.

Q. Storage:

The Pharmacist – shall insure that all medication and devices are stored according to U.S.P. storage requirements.

R. Security:

1. It shall be the responsibility of the Pharmacist, Nursing Director and/or Nursing Supervisor (or other registered nurse assigned), PA and NP registered with Pharmacy Board, and the Public Health Director to be jointly responsible for the security of the drug supply.

2. Limiting access to the pharmacy shall be maintained by approved personnel only.

3. All legend medications and devices will be kept in the pharmacy or other designated area that has the same security and storage requirements as the pharmacy.

4. All controlled substances will be kept in a designated locked area and the pharmacist will have the keys. "NO CONTROLLED SUBSTANCES WILL BE STOCKED IN THE PHARMACY AT THIS TIME".

5. Medications and devices will be stored so as to safeguard clients and staff.

6. Only approved staff will have access to the pharmacy when the pharmacist is not on-duty.

7. Immunization Refrigerator:

   a. The immunization refrigerator is equipped with an alarm system set to notify the local alarm company of any deviation of temperatures beyond set low and high parameters as specified by manufacturers.
   b. The pharmacist or designated alternate will be notified of any deviation in temperature. Attempts to solve problems will be carried out immediately during work hours and as soon as the pharmacist or designate can travel to the Division of Public Health Services after hours.
   c. Emergency storage for vaccines is provided by a local hospital which is equipped with an emergency power supply. Vaccines will be transported in styrofoam containers containing ice packets.
   d. Containers filled with water and ice packets are also stored in the refrigerator in order to maintain desired temperature in the event of a power outage. The containers are used to maintain the temperature setting until alternate arrangements can be made.
   e. The temperature of refrigerators and freezers in which medications and devices are stored will be checked twice a day and recorded.

      - The assigned nurse will alert the Pharmacist or Director of Nursing if the temperature is out of range consistently. A different thermometer will be used to verify the readings.
      - If abnormal range continues – State Immunization Branch will be notified to determine viability of vaccine and an alternate refrigerator meeting standards will be used.

S. Record Keeping:

1. A system of record keeping at the Pharmacy has been established to provide accountability for drugs and/or devices dispensed and assure an accurate record for each client.

2. This is accomplished, at this time, by the use of individual prescriptions, a sequential numbering system, and a daily prescription log produced by our dispensing software.

3. It is absolutely essential that procedures for record keeping be strictly adhered to by all dispensing personnel. It should be noted at this point that all records relating to client histories (including prescription records) are of a confidential nature, and steps to preserve this confidentiality should be a concern of all.

4. A log is maintained for any over-the-counter medications obtained by the agency staff. Any withdrawals of these medications should be documented on the log.

5. Medication Profile – is reviewed at the time the medication is filled. The following is checked to screen for potential drug therapy problems due to:

   a. therapeutic duplication;
   b. drug-disease contraindication;
   c. drug-drug interactions, including serious interactions with prescription or over-the-counter drugs;
   d. incorrect drug dosage or duration of drug treatment;
   e. drug-allergy interactions; and
   f. clinical abuse/misuse

6. All records pertaining to the filling and refilling of prescriptions shall be available to designated employees of the Board of Pharmacy during normal business hours.

T. Safety:

1. Extension cords will be used only for use of a generator, during a power outage.

2. No stools will be left within the walk area of the pharmacy.

3. All electrical equipment will be serviced and approved by the maintenance department.

4. Staff will use OSHA Approved step-stools to retrieve any items stored on high shelves.

5. Staff will not use any frayed cords. Any noticed will be reported to maintenance.

6. Staff will maintain proper body mechanics while performing duties.

U. Infection Control:

1. Staff will use any Personal Protective Equipment that may be needed while performing duties.

2. It is the staff's responsibility to protect our clients from infectious disease – This can be accomplished by:

   a. washing hands before handling medications
   b. cleaning the counting trays
   c. clean glassware with soap and water
   d. emptying dose unit containers and lids and cleaning any contamination
   e. the pharmacy floor should be vacuumed and counter tops cleaned regularly

V. Drug Recall:

1. When notice of a medication or device recall is received, and it is determined that the product or specified lot number of the product is available, the pharmacist, or his/her designee, shall immediately remove the medication or device from the pharmacy stock and retrieve all the medication as specified by the level of recall.

2. When there is a known medication or device recall, the Pharmacist or Director of Nursing will notify the Physician Extenders.

3. The information pertaining to the recall will be documented on the Manufacturer's Drug Recall Form and disseminated among the appropriate staff.

W. Drug Disposition:

1. Any medications or devices deemed unsuitable for use either because the expiration date has been reached or from damage, contamination, or for any other reason, shall be identified. These medications or devices, if not controlled substances, shall be placed in a designated area specifically for this purpose and returned to its manufacturer according to the "return goods policy". A returns company may also be used for non-controlled substances.

Credit for returned medications may be in the form of check, credit memo through wholesaler, credit memo through manufacturer, or replacement medications from manufacturer. Those medications or devices that cannot be returned in this manner will be destroyed according to the North Carolina Board of Pharmacy regulations.

2. Medication stock that cannot be sent back for credit is disposed of by the following means:

   - Some vaccines are disposed of via the BFI collection system (sharp containers).
   - Oral medications are destroyed via drug drop box at the Sheriff's Department.

3. A file shall be maintained by the pharmacy for the medications disposed.

X. Quality Assurance: Pharmacy and Therapeutics Committee

1. The Pharmacy and Therapeutics Committee consists of the Health Director, Director of Nursing, Pharmacists, Physician Extenders, Pharmacy Technicians, and Nursing Supervisors.

2. The Committee will meet at least once a year.

3. Pharmacy Formulary will be discussed.

4. The Committee will review Adverse Drug Reaction Reports from the previous year.

5. Any changes that have occurred in Pharmacy Law relevant to our Practice, major recalls, therapeutic or situational findings, and policy and procedure changes for both pharmacy and staff will be discussed.

6. Minutes for this meeting will be documented and a copy will be kept in the Pharmacy Manager's office.

7. Reporting: It shall be the responsibility of the Pharmacy and Therapeutics Committee to report directly to the Clinical Staff and Administration in connection with all duties and functions it is to perform.

Y. Natural Disaster Recovery Plan:

1. This is in response to the Pharmacy Practice Laws of the State of North Carolina.

2. The Pharmacy is not a critical care facility. The following steps are implemented to meet the ruling requirements:

    a. A copy of the pharmacy license, spare keys to the locked facility and a list of phone numbers of the Pharmacist, Supervisors, Director of Nursing and Health Director should be kept in a secure area.
    b. Access to the aforementioned items should be restricted to the Pharmacy Manager – Pharmacist, Supervisors, Director of Nursing, Health Director, State Pharmacy Director, and County Management.
    c. All reasonable steps should be taken to restore service as quickly as possible.

    In case the pharmacy is destroyed or partially destroyed by a natural disaster or fire, the medications and devices will be moved to a secured, locked area. All medications and devices not suitable for use will be destroyed according to rules and regulations of the Board of Pharmacy.

Z. Responsibilities of the Pharmacist Manager

1. The Pharmacist-Manager shall assure that prescription legend drugs and controlled substances are safe and secure within the pharmacy. At this time, no controlled substances are in the pharmacy.

2. The Pharmacist-Manager employed or otherwise engaged to supply pharmaceutical services may have a flexible schedule of attendance but shall be present for at least one-half the hours the pharmacy is open.

3. Whenever a change of Pharmacist-Manager occurs, the successor Pharmacist-Manager shall complete an inventory of any controlled substances in the pharmacy within 10 days. A written record of such inventory, signed and dated by the successor Pharmacist-Manager, shall be maintained in the pharmacy with other controlled substances records for a period of three years.

4. The Pharmacist-Manager shall develop and implement a system of inventory record-keeping and control which will enable that pharmacist-manager to detect any shortage of discrepancy in the inventories.

4. The Pharmacist-Manager shall maintain complete authority and control over any and all keys/access to the pharmacy and shall be responsible for the ultimate security of the pharmacy. The pharmacy shall be secured to prohibit unauthorized entry if no

pharmacist will be present in the pharmacy for a period of 30 minutes or more.

6. The Pharmacist –Manager shall prepare a plan to safeguard prescription records and pharmaceuticals in the event of a natural disaster such as hurricane or flood.

7. The Pharmacist-Manager will insure that all drug products more than six months out of date are separated from dispensing stock.

8. The Pharmacist-Manager shall report to the Board of Pharmacy information that reasonably suggests that there is a probability that a prescription drug or device dispensed from our location has caused or contributed to the death of a patient or customer. This report shall be filed in writing on a form provided by the Board within 14 days of the Pharmacist-Manager's becoming aware of the event.

9. Dispensing errors which are not detected and corrected prior to the patient receiving the medication shall be documented and reported to the pharmacist-manager. Documentation shall include pertinent chronological information and appropriate forms including the identity of individual(s) responsible. These documents, including action taken as part of a quality assurance plan, shall be archived in a readily retrievable manner and open for review, copying or seizure by the Board of its designed employees within 48 hours of a request for inspection for a period of three years. These documents shall be released only to the Board of its designated employees pursuant to an investigation and shall not otherwise be released except as required by law. Upon request by the Board of its designated employees, these documents shall be transmitted by the Pharmacist-Manager to an office of the Board.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PHARMACY DOCUMENTATION GUIDELINES

DATE DEVELOPED: 8/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 2/03; 3/04; 3/09; 6/14; 6/17; 6/18

I. POLICY:

The Division of Public Health Services will follow the guidelines listed below when completing any pharmacy documentation.

II. PURPOSE:

To provide appropriate guidelines for uniformity of pharmacy services documented as necessary.

III. GUIDELINES:

A. The client's name and clinical record number must appear on every page of the chart.

B. Date all entries. Some entries may require the time documented.

C. Sign every entry made and include professional initials.

D. Telephone or verbal orders should be signed "T.O. or V.O.".

E. Entries are permanent.

1. Use black ink.

2. Be accurate, timely, precise, objective, and legible.

3. Use agency approved abbreviations.

4. To correct entries – draw a single line through the error, write date, initials above entry, and write corrected entry to the side.

5. The pharmacist will document in the client's chart on the medication sheet.

F. Written medication orders:

1. All prescription documents must be printed using legible handwriting.

2. Prescription orders should include a brief notation of indication for use in the client's chart.

3. Prescriptions should be written in the metric system except for insulin that uses standard units.

4. All orders should include full drug name, exact metric weight, or concentration dosage form, and complete instructions including route and frequency.

5. All medication orders should include client specific information such as name, age, and sex. Height, weight, and allergy information should be included either on the prescription or available in the client's chart.

6. Number orders and write only one order per line on prescription.

7. Write orders in black ink, no felt tip pens are to be used.

8. Any orders which are illegible or incomplete should be clarified with the physician extender who executed the order.

G. Labeling of medication that are pre-packaged by the pharmacist:

1. The label will contain:

   a. NDC #
   b. Medication name
   c. Strength
   d. Number of units contained
   e. Expiration date
   f. Date pre-packaged
   g. Pharmacist's initials

2. The minimum information required on a prescription label, shall include, but not be limited to the following information:

   a. Name and address of Pharmacy

b. Name of client
c. Date of filling
d. Serial number of the prescription
e. Name of prescriber
f. Phrase "Filled by" or "Dispensed by" with the name of the practitioner who dispenses the prescription appearing in the blank
g. Directions for use
h. Name, quantity of drug and strength of drug, unless otherwise directed by prescriber
i. The use of auxiliary labels to provide additional information to the client about the drug is recommended
j. The brand name of any drug product dispensed or in the absence of a brand name, the established name.
k. The discard date when dispensed in a container other than the manufacturer's original container. The discard date shall be the earlier of one year from the date dispensed or the manufacturer's expiration date, whichever is earlier.

3. Patient Advisory Leaflet is printed for each prescription that details:

a. Patient information
b. Drug – including generic name if applicable
c. Common uses
d. How to use this medication
e. Cautions
f. Possible side effects

4. A label is generated for the patient counseling record. It shows:

a. Prescription information
b. States whether patient was counseled
c. The signature of person receiving prescription
d. These labels are stored in notebooks for **one** year.

5. Labels are also available that are blank with a spot to write:

a. Patient name
b. Drug and strength
c. Signature of the person receiving prescription.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: FORMULARY

FOR PERSONS APPROVED TO PRESCRIBE, ORDER OR DISPENSE DRUGS UNDER THE PROVISIONS OF NCGS 90-18.1 AND 90-18.2 AND RULES NCAC 32L AND 21 NCAC 32M

DATE DEVELOPED: 6/16/98
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

The Rockingham County Health and Human Services Board and Medical Director authorizes the pharmacist to dispense medications and devices according to the following formulary.

II. PURPOSE:

To identify specific medications and devices and their generic equivalent which may be ordered and dispensed within the Division of Public Health program services.

III. GUIDELINES:

A. NO PARENTERAL PREPARATIONS may be prescribed, ordered or dispensed except Insulin; Immunizations of DPT, MMR, HIB, Tetanus Toxoid, DT; Hyperimmune Serum; Epinephrine; Benadryl; Pneumovax; Flu Vaccine; Hepatitis B Vaccine; Depo Provera; Depo Medrol and local anesthetics.

B. EXCLUDED DRUGS: Any pure form or combination of the following generic classes of drugs may be prescribed, ordered, or dispensed unless the drug or class of drug is listed as excluded by the formulary. No drugs or classes of drugs that are excluded may be prescribed, ordered, or dispensed except as permitted by Rules 32L and 32M.

C. REFILLS: A prescription for a non-controlled substance may indicate a refill up to one year. However, the Division of Public Health Services may not be able to supply the refill.

D. PRESCRIPTION NOTATION: Every prescription must be noted on the client's chart.

E. WRITTEN STANDING ORDERS: According to NCGS 90-18.1 and 90-18.2 written standing orders may be used.

F. PHARMACEUTICALS: The Providers may make Formulary requests when certain medications are needed. These requests can be verbalized to a Pharmacist who in return must notify all Providers, in writing, of additions to the Formulary.

Rev/di

ROCKINGHAM COUNTY DIVISION OF HEALTH AND HUMAN SERVICES
PHARMACY FORMULARY
May 2019

NAME	STRENGTH	FORM	NOTES
ANALGESICS			
Aspirin Chew	81mg	Tabs	
Acetaminophen	325mg	Tabs	
Acetaminophen	160mg/5ml	Drops	
Acetaminophen	160mg/5ml	Elixir	
Ibuprofen Infant	50mg/1.25ml	Drops	
Ibuprofen Children	100mg/5ml	Elixir	
Ibuprofen	200mg	Tabs	
Ibuprofen	800mg	Tabs	
Naproxen	220mg	Tabs	
ANESTHETIC OR CLINIC USE			
Acetic Acid	5%w/v	Soln	
Ferric Subsulfate (Monsel's)	20-22%	Soln	
Lidocaine	1%	Inj	
Sterile Water			
ANTIBIOTICS			
Amoxicillin	250mg/5ml	Susp	
Amoxicillin	400mg/5ml	Susp	
Amoxicillin	500mg	Caps	
Azithromycin	200mg/5ml	Susp	30ml stock size
Azithromycin	250mg	Tabs	5 day dose pk
Ceftriaxone	250mg	Inj	Vials powder
Cephalexin	500mg	Caps	
Ciprofloxacin	500mg	Tabs	
Clindamycin	300mg	Caps	
Doxycycline Hyclate	100mg	Caps	
Doxycycline Monohydrate	100gm	Caps	
Gentamicin	80mg/2ml	Inj	
Levofloxacin	500mg	Tabs	
Metronidazole	500mg	Tabs	
Metronidazole Vag	0.75%	Cream	
Nitrofurantoin Macrocrystals	100mg	Caps	Macrodantin
Nitrofurantoin Mono/Macro	100mg	Caps	Macrobid
Sulfamethoxazole/Trimeth	800mg/160mg	Tabs	Septra DS
Xifaxan	550mg	Tabs	

ANTIBIOTICS/ANTIVIRALS STATE SUPPLIED FOR STD USE

Acyclovir	400mg	Tabs	
Azithromycin	500mg	Tabs	
Bicillin LA	1,200.000units	Vial	Pen G Benzathine
Ceftriaxone Sodium	250mg	Vial	Rocephin
Cefixime	400mg	Tabs	Suprax
Doxycycline Mono	100gm	Caps	
Metronidazole	500mg	Tabs	
Tinidazole	500mg	Tabs	
Valacyclovir	500mg	Tabs	
Valacyclovir	1000mg	Tabs	

ANTICONVULSANTS/NEUROLOGICAL

**Dilantin PAP			
Gabapentin	100mg	Caps	
Gabapentin	300mg	Caps	

ANTIDEPRESSANTS (Enroll patients into PAP for Prozac, Zoloft, Cymbalta, etc.)

ANTIFUNGAL			
Clotrimazole Vag	2%	Cream	
Fluconazole	150mg	Tabs	
Ketoconazole	2%	Cream	30gm
Nystatin	100,000units	Susp	
Nystatin		Cream	
Terbinafine	250mg	Tabs	
Terconazole Vag	0.4%	Cream	

Antituberculosis-State Supplied

Rifapentine	150mg	Caps	
Ethambutol	400mg	Tabs	
Isoniazid	300mg	Tabs	
Pyrazinamide	500mg	Tabs	
Pyridoxine HCL	25mg	Tabs	B-6
Rifampin	150mg	Caps	
Rifampin	300mg	Caps	

ANTIVIRALS

Acyclovir	400mg	Tabs	
Tamiflu	75mg	Caps	

CARDIOVASCULAR/CHOLESTEROL/ANTIPLATELET

Amlodipine	5mg	Tabs
Amlodipine	10mg	Tabs
Atenolol	50mg	Tabs
Atenolol	100mg	Tabs
Atorvastatin	40mg	Tabs
Bisoprolol Fumarate	10mg	Tabs
Bisoprolol/HCTZ	10mg/6.25mg	Tabs
Carvedilol	3.125mg	Tabs
Carvedilol	6.25mg	Tabs
Clonidine	0.1mg	Tabs
Clonidine	0.2mg	Tabs
Clopidogrel	75mg	Tabs
Furosemide	40mg	Tabs
Furosemide	80mg	Tabs
HCTZ	25mg	Tabs
HCTZ	50mg	Tabs
Lisinopril	5mg	Tabs
Lisinopril	10mg	Tabs
Lisinopril	20mg	Tabs
Lisinopril/HCTZ	20mg/12.5mg	Tabs
Lisinopril/HCTZ	20mg/25mg	Tabs
Metoprolol	25mg	Tabs
Metoprolol	50mg	Tabs
Nitroglycerin	0.4mg	Tabs
Pravastatin	40mg	Tabs
Rosuvastatin	10mg	Tabs
Rosuvastatin	20mg	Tabs
Simvastatin	20mg	Tabs
Spironolactone	25mg	Tabs

COUGH/COLD

Banophen Liq	12.5mg/5ml	Liquid
Benzonatate	100mg	Caps
Diphenhydramine	25mg	Tabs
Fluticasone Nasal	50mcg	Nasal Spray
Hydroxyzine HCL	25mg	Tabs
Loratadine	10mg	Tabs
Montelukast	10mg	Tabs

DENATL RINSE

Chlorhexidine Gluconate	0.12%	Oral Soln

DERMATOLOGICALS

Aldara	5%	Cream	(Imiquimod)
Hydrocortisone	1%	Packs	
Silver Sulfadiazide	1%	Cream	
Triamcinolone	0.5%	Cream	
Vitamin A&D		Oint	
Mupirocin		Oint	
Nix Lice Treatment		Pkg	
Permethrin		Lotion	
Permethrin	5%	Cream	
Rid Lice Spray		Spray	
Triple Antibiotic Oint		Packs	

EAR

Debrox	6.5%	Soln
Ear Wax Kit	6.5%	Kit
Neomycin/Polymyxin B/HCT	3.5mg/10,000/10mg	Soln

EYE

Erythromycin	0.5%	Oint
Polymyxin/Trimethoprim	10ml	Soln
Tobramycin	0.3%	Soln

ENDOCRINE SYSTEM
*Enroll patients into PAP Insulins

Novolin R		Vial	
Novolin N		Vial	
Humalog		Vial	
Glipizide	10mg	Tabs	
Metformin	500mg	Tabs	
Metformin	1000mg	Tabs	
Glucose Gel	15gm	Gel	
Dex4	4gms	Tabs	Chewable

GOUT MEDICATIONS

Allopurinol	100mg	Tabs

STEROIDS

Depo-Medrol	80mg/ml	Inj	Methylprednisolone
Prednisone	10mg	Tabs	

FAMILY PLANNING

Condoms			
Depo-Provera	150mg	Inj	Medroxyprogesterone
Depo-subQprovera	104mg	Inj	
Ella	30mg	Tabs	
Mirena			
My Way	1.5mg	Tabs	Levonorgestrel
Nexplanon			
Paragard			
Skyla			

ORAL CONTRACEPTIVES

Levonorgestrel/Ethinyl Estradiol	0.1mg/.02mg	Tabs	Sronyx
Levonorgestrel/Ethinyl Estradiol	0.15mg/0.3mg	Tabs	91 tabs Jolessa
Lo-Sesonique	0.1mg/02.mg	Tabs	91 tabs
Low-Ogestrel "Lo-Ovral"	0.3mg/.03mg	Tabs	Norgestrel/Ethinyl Estr
Microgestin Fe 1/20 "Loestrin Fe"	0.1mg/.02mg	Tabs	Norethindrone/Ethinyl
Necon 0.5/35	0.5mg/.035mg	Tabs	Norethindrone/Ethinyl
Norethindrone	0.35mg	Tabs	Ortho Micronor
Nortrel 0.5/35	0.5mg/.035mg	Tabs	Norethindrone/Ethinyl
Nortrel 7/7/7	Triphasic	Tabs	Ortho Novum 7/7/7
Ortho-Tri Cyclen	Triphasic	Tabs	Norgestimate/Ethinyl
Sprintec	0.250mg/.035mg	Tabs	Ortho-Cyclen
Tri-Lo-Marzia "Ortho-Tri-Cyclen Lo"	Triphasic	Tabs	Norgestimate/Ethinyl
Velivet	Triphasic	Tabs	Desogestrel/Ethinyl

VAGINAL

Nuvaring	0.12/0.015	Vag	Vaginal Ring

FIRST AID

Ammonia Inhalant	1mg/ml	Inj	Unit dose
Epinephrine	1mg/ml	Inj	Unit dose
NaCl	0.9%	Inj	

GASTROINTESTINAL MEDS

Calcium Carbonate (Tums)	1000mg	Tabs	
Loperamide	2mg	Tabs	
Omeprazole	20mg	Caps	
Pantoprazole	40mg	Tabs	
Ranitidine	150mg	Tabs	
Simethicone	125mg	Tabs	

GENITOURINARY

Finasteride	5mg	Tabs	
Tamsulosin	0.4mg	Caps	

MUSCLE RELAXERS

Cyclobenzaprine	10mg	Tabs	

RESPIRATORY
**PAP for inhalers

Albuterol Sulf Soln	2.5mg/3ml	Soln	Nebulizer Soln

SUPPLEMENTS

Vitamin D2	1.25mg(50,000 units)	Caps	
Prenatal Plus		Tabs	

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: THERAPEUTIC SUBSTITUTION

DATE DEVELOPED: 8/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18

I. POLICY:

The Rockingham County Department of Health and Human Services Board, Medical Director, and Supervising Physicians authorize the pharmacist to dispense the generic equivalent of medications ordered by their trade name. Nurse Practitioners/Physician Assistants will sign the line "substitution permitted" on prescriptions.

II. PURPOSE:

To provide the opportunity to prescribe and dispense the generic brand of medications as well as identify certain medications that may need therapeutic substituting. This will allow the agency to purchase and obtain the most cost effective pharmaceuticals and achieve the desired health outcome.

III. GUIDELINES:

A. The Physician Extender will identify The Therapeutic Substitution of drugs that can be used within their program.

B. When an order is written for one of these medications, the approved therapeutic equivalent may be dispensed unless the physician extender writes "NO SUBSTITUTION" on the order.

C. Therapeutic substitution is documented in formulary.

D. Any change of dose or schedule will be noted. This will be signed by the pharmacist and does not require a counter signature by the physician.

No "narrow range" therapeutic drugs (see list) (by Board Rx) or birth control pills unless Physician Extender approves will be substituted.

Therapeutic Substitutions Currently Accepted:

Proventil HFA Inhaler = Albuterol Inhaler = Ventolin HFA = ProAir HFA
Jolessa = Levonorgestrel/Ethinyl Estradiol 0.15mg/0.03mg
Cryselle = Low-Ogestrel
Sronyx = Levonorgestrel/Ethinyl Estradiol 0.1mg/0.02mg

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PRESCRIPTION ASSISTANCE PROGRAM (PAP)

DATE DEVELOPED: 3/03
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

The Division of Public Health Services may provide Prescription Assistance to those clients that meet eligibility guidelines.

II. PURPOSE:

To provide prescription assistance to clients who do not have prescription insurance such as Medicaid, Medicare, or private insurance coverage.

III. GUIDELINES:

A. This program is limited to clients of the Division of Public Health Services.

B. Clients MUST NOT have private insurance or be covered by any other 3rd party program that pay or help pay for their medications.

C. Clients must submit copies of W-2 forms, income tax forms, social security letters, or any other proof of income required by the specific manufacturer's prescription assistance program to which they are applying for medications to be ordered.

D. To determine eligibility for the PAP program, the client's drug must be covered by the manufacturer's prescription assistance program AND the client must be eligible for the specific manufacturer's program based on their income.

E. Referrals into the program are made by the providers at the Division of Public Health. After the referral is made, the client is asked to make an appointment with our Prescription Assistance Coordinator to enroll in the program.

F. The Prescription Assistance Coordinator is at the Division of Public Health Services from 8:00 am to 5:00 pm Monday-Friday.

G. The Prescription Assistance Coordinator re-orders medication every two months for our clients.

H. If the client cannot pick up their medication, it will be necessary for them to send written approval to obtain their prescriptions.

I. Clients enrolled in this program must be evaluated at least annually by their health care provider. More frequent visits may be warranted depending on the client's medical condition.

J. Medications that are received from the manufacture's assistance programs are dispensed at the Division of Public Health Pharmacy. Clients are counseled by the Pharmacist on new medication orders. For clients who may need additional medication management, a clinical Pharmacist is available upon referral.

K. Failure to abide by the Prescription Assistance Program or Division of Public Health policies can lead to dismissal from the Prescription Assistance Program.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CO-PAYMENT FOR MEDICATIONS AND DEVICES

DATE DEVELOPED: 9/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16

I. POLICY:

The Division of Public Health Services will charge Adult Health Primary Care clients a co-payment on medications and devices if clients meet eligibility guidelines.

II. PURPOSE:

To identify the population eligible to receive medications or devices through the Division of Public Health Services Pharmacy. Those clients eligible to receive Adult Health Primary Care services will be charged a co-payment for medications or devices.

III. GUIDELINES:

A. The Adult Health Primary Care Program will identify eligibility of the population to receive services.

B. Those clients who are above the program eligibility guidelines are not eligible to receive Division of Public Health Services Pharmacy assistance. Clients who are not eligible for pharmacy assistance and above eligibility guidelines will be identified by writing 100% pay on the encounter form. These clients are provided a prescription to be obtained at an outside pharmacy.

C. Clients with Medicaid coverage will be given a prescription for any required medications or devices to obtain from an outside pharmacy.

D. Clients with private insurance coverage for prescription medications will be provided a prescription for any required medications or devices to obtain from an outside pharmacy.

E. Clients who cannot obtain their medications at a reduced cost from an outside Pharmacy (equal to or below our agency's co-payment), who meets our agency's eligibility criteria, may receive up to a 30-day supply with 1 refill on their chronic disease medications in our Pharmacy within a 12-month period. During this time, providers should enroll the client in the

agency's Prescription Assistance Program (PAP) for all their maintenance medication that the drug manufacturer's supply.

F. Clients who are prescribed birth control pills in the agency's Family Planning Clinic may receive refills on their original maintenance prescription (up to 13 packs per year) per provider's discretion. Clients may receive a lesser amount due to expiration dates of the medications. This pertains only for oral contraceptives filled at the Division of Public Health Services' Pharmacy.

G. There is a $4.00 co-payment charge for receiving medications (county funded) through the Division of Public Health Pharmacy. See program specific requirements for FP/STD.

Any exceptions to this policy must be approved by the Health Director, or in his/ her absence, the Director of Nursing.

Rev /di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: EMPLOYEE ACCESS TO MEDICATIONS DURING WORK HOURS

DATE DEVELOPED: 4/15/98
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18

I. POLICY:

Division of Public Health Services employees may obtain certain medications from the pharmacy during work hours.

II. PURPOSE:

The employee may receive a medication to become pain free or symptom free and remain at work.

III. GUIDELINES:

A. Medications received from the pharmacy are listed on the approved formulary.

B. Medications are to be administered in one or two doses only.

C. No medication will be administered, without a thorough history of allergies and contraindications to medications presently being taken by the employee.

D. Employees will be given thorough instructions on how to take or apply medication if they require it.

E. The nurse or pharmacist administering the medications and the employee will document on the OTC Log on the pharmacy clipboard.

Formulary:

Analgesics:

Ibuprofen 200 mg: One or two tablets every 6 to 8 hours.

Acetaminophen 325 mg: Two tablets every 4 to 6 hours

Antihistamine:

Diphenhydramine 25 mg: One or two capsules every 4 to 6 hours.

Loratadine 10 mg: 1 tablet daily

Decongestant:

Sudafed PE (Phenylephrine) 10 mg: One tablet every 4 hours.

Anti-Diarrheal:

Loperamide HCL 2 mg: Two caplets after first loose bowel movement and one caplet after each subsequent loose stool. No more than 4 caplets in 24 hours.

Topical Corticosteroid:

Hydrocortisone Cream USP 1% - Apply to affected area 2-4 times daily.

Local Anti-Infectives:

Neosporin Ointment: Apply to affected area 1 to 3 times daily.

Antacid Absorbents and Antiflatulents:

Mylanta Gas: (Simethicone) Chew 1-2 tablets as needed after meals.

Tums (Calcium Carbonate) 750 mg: Chew 2-4 tablets as symptoms occur.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: DISPOSAL OF MEDICATIONS AND DEVICES

DATE PREPARED: 8/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/18

I. POLICY:

Division of Public Health Services pharmacy staff will check the expiration dates of medications and devices *at least every month*. Those that are expired will be disposed of according to the Board of Pharmacy Regulations or sent back to wholesaler for credit. Expiration dates are also checked by the professional dispensing the med, prior to filling each prescription.

II. PURPOSE:

To delineate the method of disposal of medications and devices for which the expiration date has been reached.

III. GUIDELINES:

A. The pharmacist and assigned staff will observe the expiration date of inventory stock.

B. Medications and Devices received through the vaccine program will be disposed of following the policies and procedures of that program.

C. All other expiring medications and devices will be pulled from the dispensing area, placed in a designated area, and disposed of according to the Board of Pharmacy Regulations.

D. Unless otherwise stated, the medications or devices may be dispensed through the end of the date stated on the manufacturer's label (e.g., Oct, 2012)

E. Medication stock is disposed of by the following means:

- Some vaccines are disposed of via the sharp containers.
- Inhalers, liquids, and oral medications that cannot be sent back for a manufacture's credit are destroyed via the Sheriff's Department during "Med Drop Off".

- Those medications that can be returned to the wholesaler or manufacturer will be written up on the proper forms provided by the company. A returns company may also be used for some medications. Credit for returned medication may be in the form of a check, credit memo, or medication replacement.

F. A file shall be maintained by the pharmacy. All medications disposed of are logged on the "Drug Disposal" form.

G. Any medications dispensed by the Division of Public Health Services to clients of the Division of Public Health that are returned to the Pharmacy by a Registered Nurse, Nurse Practitioner, or Physician Assistant will be inventoried for disposal by the Pharmacist. To assure medications are disposed of per count regulations, the Pharmacist uses the "Med Drop Off" disposal dates/sites conducted by the Rockingham County Sheriff's Department (these are scheduled 2-3 times per year) or use the drop box located at the Sheriff's Department.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PHARMACY STUDENTS

DATE DEVELOPED: 8/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The Division of Public Health Services has been approved to serve as a clinical site by the University of North Carolina School of Pharmacy and Campbell University School of Pharmacy for their pharmacy clinical rotations.

II. PURPOSE:

To allow pharmacy students the opportunity to become familiar with the operation of a Division of Public Health Services and Division of Social Services Pharmacy.

III. GUIDELINES:

A. The pharmacist coordinates the student's clinical rotation with the school coordinator. A syllabus has been given to the UNC School of Pharmacy for the student's planned events and studies.

B. The student will be given an orientation of the Division of Public Health Services and trained according to our Infection Control Policies and HIPAA. He/she is expected to follow all policies of the Division of Public Health Services.

C. The student will also be given the opportunity to rotate through the various agency and community programs including Division of Social Services.

D. The student's work schedule will be maintained according to his/her school requirements.

E. The student's preceptor is responsible for his/her paperwork, education and grading during his/her Public Health rotation.

F. Confidentiality will be maintained as follows: The student will sign a confidentiality statement upon orientation.

G. The student will be given the opportunity to attend any related meetings.

H. It is encouraged that the student be given the opportunity to provide an in-service training session for agency staff or community group.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PROCUREMENT/INVENTORY CONTROL/PROPERTY MANAGEMENT OF FEDERAL DRUG PRICING PROGRAM (340B) MEDICATIONS FOR FAMILY PLANNING, SEXUALLY TRANSMITTED INFECTION, AND TUBERCULOSIS

DATE DEVELOPED: 4/11/12
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/18

I. POLICY:

Division of Public Health Services purchases medications from the Federal Drug Pricing Program (340B) for the specific programs of Tuberculosis (TB), Sexually Transmitted Infection (STI), and Family Planning Birth Control (BC). The Division of Public Health Federal Drug Pricing Program (340B) requirements as they relate to pharmaceuticals.

II. PURPOSE:

The Division of Public Health Services will provide medications for treatment/ control of tuberculosis and sexually transmitted infection. Contraceptives are provided to reduce unintended pregnancies and improve selected health practices among low income families.

III. GUIDELINES:

A. The Pharmacy Manager will keep a perpetual inventory system to control purchase, use, and for reordering of medications and supplies.

B. The Division of Public Health has adequate safeguards in place to assure that supplies purchased through the Federal Drug Pricing Program (340B) are provided only to clients. Prescriptions are only filled upon receipt of a written/electronic prescription from the clinic. No outside prescriptions are filled for 340B medications.

C. The pharmacy will operate in accordance with federal and state laws relating to security and record keeping for drugs and devices.

D. The inventory, supply, and provision of pharmaceuticals will be conducted in accordance with state pharmacy laws and professional practice regulations by the Pharmacy Manager.

IV. FEDERAL DRUG PRICING PROGRAM REQUIREMENTS FOR PHARMACEUTICALS

A. The Pharmacy Manager and Family Planning Supervisor will maintain an adequate supply and variety of drugs and devices to effectively manage the contraceptive needs of the clients.

B. The Pharmacy Manager and Family Planning Supervisor will maintain necessary drugs or devices for the provision of any other services that is included within the scope of the Title X Project for the Family Planning Program.

V. DISPENSING 340B MEDICATIONS TO CLIENTS/PATIENTS

A. A prescription is generated by the licensed practitioner or written by the RN under standing orders from the MD.

B. The prescription is filled by the pharmacist or a RN trained in dispensing medications using medication provided free of charge for BC, STI or TB patients only.

C. A label is generated by the computer and placed on the prescription bottle containing the patient's name, the date, and directions for taking medication, the name and quantity of medication, the name of practitioner/provider, and the prescription number.

D. An audit copy of the label is produced also containing the NDC number of the drug. This is placed on the back or front of the written prescription.

E. The patient is counseled on the use of the drug and sign the "patient counseled" sticker to be placed in the patient's chart.

VI. 340B MEDICATIONS ADMINISTERED TO CLIENTS/PATIENTS

A. Drugs are prepackaged by the pharmacist for use in the clinic to be administered to the patient by the RN.

B. Individual STI drug dosage is packaged in the bottle, labeled with the drug name (generic and trade name if applicable), strength of drug, form of drug, quantity of drug, NDC number, manufacturer's number, date filled, lot number, pharmacist's initials, if drug is state or county supplied, and expiration date.

C. Two labels are generated and placed on the bottle by the Pharmacist. STI drugs are signed out from the pharmacy in multiple lots using "Sign-Out Book for STI" and taken to the clinic for secure storage.

D. The RN counsels patient on individual medication before administering the dose of STI medication in the clinic.

E. One label containing drug information if removed from the bottle and placed on the patient sign out sheet.

F. The other label is removed from the bottle and placed in the patient's chart and the patient's signature is recorded.

G. IUDs and Depo-medroxyprogesterone are signed out from the pharmacy in the "Sign-Out Book" by the RN and administered to the patient in the clinic. This is documented in the patient's chart.

H. The 340B sign out sheets are completed by the RN and placed in the 340B log book titled "Completed 340B Sheets" located in the pharmacy.

VII. INVENTORY CONTROL AND PROPERTY MANAGEMENT

A. The Pharmacy Manager will keep an inventory log of all Title X devices and medications used in the Family Planning Clinic.

B. The RN will obtain single dose Depo-Provera and pre-packaged STD 340B meds from the pharmacy to maintain stock in the Family Planning/STD Clinic. The RN will sign out for STD medication and Depo-Provera single dose units (150 mg and 104 mg) on the Drug Sign-Out Sheet for RN's located in the pharmacy. To complete the sign out sheet, the RN will indicated the name of the drug, the date, the NDC number, lot number and the expiration date, quantity, and the RN's signature.

C. The RN will take the inventory and leave a note for the Pharmacy Manager to record in the 340B notebook.

D. For Quality Assurance, upon return of the completed "Patient Drug Sheet", the Pharmacist compares it to the "Drug Sign-Out Sheet for RN's" to verify for accuracy.

E. Weekly inventory is performed by the Pharmacy Manager.

F. The Pharmacy Manager checks for out of date stock. Stock is rotated and as new stock arrives, the newest stock is placed in back.

G. Daily reports are reviewed/audited by the Pharmacy Manager.

H. Pharmacy will maintain a minimum of three month's supply of all commonly used STD drugs in the event of shortages.

VIII. PURCHASES OF FAMILY PLANNING SUPPLIES AND CONTRACEPTIVES

Pharmacy Manager will purchase TB medications, STI medications, contraceptives and supplies as needed through the Federal Drug Pricing Program (340B).

IX. 340B MATERIAL BREACH

"Material Breach" refers to an instance of non-compliance with any of the 340B Program requirements. Examples include: a facility that uses the 340B Program while not being eligible, a facility providing 340B drugs to ineligible patients, 340B drugs go missing in a facility's inventory, and a facility billing for 340B drugs contrary to an organizations Medicaid Exclusion File (MEF) status.

A. Establish Threshold

1. Materiality assessed: Weekly, hand counted by Pharmacy Manager.
2. Self-Disclosure to HRSA: If material breach, threshold breached.
3. Corrective Action: If 3 consecutive weeks outside of 10% threshold then contact HRSA.

B. Internal Investigation

Step 1: Recount medication
Step 2: Print out drug recall report list for past year
Step 3: Compare report list to 340B Drug Inventory log
Step 4: If still not fixed, pull daily logs back to date where inventory was correct. Look for any fills that were voided out and would not show up on the report list. (If not seen, the medication left the pharmacy without a prescription.)
Step 5: If still not fixed, ask the pharmacy staff and clinic staff if they know anything about missing medication.
Step 6: If still unable to figure out what happened to medication, then self-correct by ordering off of the 340B (DO NOT ORDER AS 340B MEDICATION) and fix 340B supply with county supply.

If the 340B inventory for any medication is outside of the 10% threshold for 3 consecutive weeks (has not been corrected or has been corrected but continues to be off), then contact Health Resources & Administration (HRSA) and let them know.

/di

340B DRUG INVENTORY

Drug **Strength**

NDC # **Manufacturer**

Date	Lot # / Expiration Date	Quantity Received	Current Inventory	Total Inventory on Hand	Quantity Dispensed	Theoretical Inventory	Actual Physical Count	Discrepancy Amount

Name of Drug

Date	Patient Label	Drug Label	Amt. Pham.	Amt. Given	Balance	RN Signature

Drug Sign-Out Sheet for RNs

Name of Drug: _____

Date	NDC # Lot # and Expiration	Quantity Taken	Signature of RN

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CHAIN OF CUSTODY FOR PAP MEDICATION PROGRAM

DATE DEVELOPED: 7/12
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/15; 6/17; 6/23

I. POLICY:

The Division of Public Health Services will secure all Prescription Assistance Program (PAP) and Community Assistance Program (CAP) medications via chain of custody log forms.

II. PURPOSE:

To provide accurate tracking of all PAP/CAP medications delivered to the Division of Public Health Services until disposition to the client. PAP medications enter the Division of Public Health via delivery service (Fed Ex, UPS) or US Mail.

III. GUIDELINES:

A. For All PAP/CAP Medications delivered via delivery service:

1. Medication packages that enter via the delivery service will be delivered to the second floor. These medication packages will remain unopened until they enter the Pharmacy.

2. Each medication package should be visualized/inspected. This is to be done prior to the delivery service leaving the floor. There should be no exceptions.

3. After all medication packages have been signed for, Management Support Staff will call the Pharmacy and have a PAP/CAP coordinator pick up medication packages (a nursing supervisor will be notified should PAP/CAP coordinator not be available).

4. The PAP/CAP coordinator will gather the unopened medication packages and transport to the Pharmacy. Medications are logged in to the computer by the PAP/CAP coordinator and are stored in the Pharmacy until the client presents to claim the medications in accordance to Pharmacy rules.

5. All pharmaceuticals for the PAP/CAP must be placed in the Pharmacy by the close of business daily.

B. For medications arriving via US Mail Delivery Service:

1. The Personnel Technician receives packages delivered via US mail and distributes them to the Pharmacy Department. The delivery will not be opened.

2. The PAP/CAP coordinator will claim the unopened medication packages.

3. Upon entry to the Pharmacy, medication packages received will be visualized/inspected by the PAP/CAP coordinator. This is to be done prior to the medication being stored. There should be no exceptions.

4. Medications are entered into the computer by the PAP/CAP coordinator upon opening. After entry into the computer, patients are called for pickup.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ENROLLMENT AND REORDER PROCESS FOR PAP MEDICATION PROGRAM

DATE DEVELOPED: 5/15
REVIEWED: 6/16; 6/17; 9/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 9/17

I. POLICY:

The Division of Public Health Services will process all applications (enrollment) forms and medication reorder requests in the same manner for the Prescription Assistance Program.

II. PURPOSE:

To provide accurate tracking of all Prescription Assistance Program (PAP)/ Community Assistance Program (CAP) medication enrollments, reordering processes including prescriptions and any other documentation provided regarding the client/patient enrollment process.

III. GUIDELINES:

A. For All PAP/CAP Medication application and/or reordering of medications for the PAP/CAP program the following will apply:

1. All client files for CAP will be kept in the office of the Coordinator located on the second floor. Copies of CAP clients' financial documentation will also be kept in the Pharmacy.

2. The staff person completing the application or reorder process will be responsible for filing the information in the record which is kept in a secured designated area.

3. A copy of any document faxed to a physician for signature for ordering or reordering medications must be kept until the physician sends the signed copies back. When the signed copies are received and reviewed, the unsigned copies of everything except prescriptions may be destroyed. The copy of the prescription before the signature and after the signature must be kept in the client record to prove no alterations were made. Signed copies of the applications and reorder forms will also be kept. Confirmation of faxes will be maintained in the client's folder.

4. The Coordinator must not cut or alter any prescription for any reason.

5. Each coordinator must keep all required documentation, signed and dated by the coordinator when received, in the client's folder. This may include incoming mail and faxes and all prescriptions.

6. Do not cut/alter any prescription for filing or any other reason.

7. Continue to document in Pharmacy Connections (software used for processing) elaborating what occurred with each event in Pharmacy Connections.

8. Keep a record of all clients as you enroll them in the program and submit for audit selection to staff development.

9. All PAP/CAP staff will participate in chart audit as determined by staff development.

B. Physician Request for specific Handling of prescriptions.

Currently, Belmont Medical Associate's will only accept and send prescriptions via mail.

Rev/di

I have reviewed the “Enrollment and Reorder Process for Pap Medication Program Policy”.

_____	_____
Pharmacy Manager	Date
_____	_____
Health Director	Date
_____	_____
Director of Nursing	Date
_____	_____
PAP Coordinator	Date
_____	_____
CAP Coordinator	Date
_____	_____
CAP Coordinator	Date

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMMUNITY ASSISTANCE PROGRAM (CAP)

DATE DEVELOPED: 10/15
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/18; 6/23

I. POLICY:

The Division of Public Health Services may provide Medication Assistance to those clients that meet eligibility guidelines.

II. PURPOSE:

To provide medication assistance to clients who do not have prescription insurance such as Medicaid, Medicare, or private insurance coverage.

III. GUIDELINES:

A. This program is limited to referrals from physicians of patients who are citizens of Rockingham County.

B. Clients MUST NOT have private insurance or be covered by any other 3rd party program that pays or helps pay for their medications.

C. Clients must submit copies of W-2 forms, income tax forms, social security letters, or any other proof of income required by the specific manufacturer's prescription assistance program to which they are applying for medications to be ordered.

D. To determine eligibility for the CAP program, the client's drug must be covered by the manufacturer's prescription assistance program AND the client must be eligible for the specific manufacturer's program based on their income.

E. Community Assistance Program coverage is available for medications to treat CHRONIC illnesses such as diabetes, hypertension, cholesterol, etc.

F. Referrals into the program are made by physicians. The client is asked to make an appointment with our Community Assistance Program (CAP) Coordinator to enroll in the program. Clients cannot be accepted into the program without a referral from his/her physician.

G. The CAP Coordinator works 20 hours per week not to exceed 1000 hours per year.

H. The CAP Coordinator or the Pharmacy Tech re-orders medication every 2-3 months for our clients.

I. If the client cannot pick up their medication, it will be necessary to provide authorization by telephone or note for someone else to obtain their prescriptions from the Pharmacy.

J. Clients enrolled in this program must be evaluated at least annually by their health care provider. More frequent visits may be warranted depending on the client's medical condition and the physician's requirements.

K. Medications that are received from the manufacture's assistance programs are dispensed at the Division of Public Health Pharmacy. Clients are counseled by the Pharmacist on new medication orders.

L. Medication management must be provided by the physician's office.

M. Failure to abide by the CAP program guidelines or Division of Public Health policies can lead to dismissal from the CAP program.

N. The Pharmacist will verify the accuracy of the prescription information entered into the computer by the CAP Coordinator from records provided by the physician's office or from labels on the prescription bottles.

O. A record will be kept in the Pharmacy on each new patient that is put into the system.

/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PROCUREMENT/INVENTORY CONTROL/PROPERTY MANAGEMENT OF FEDERAL DRUG PRICING PROGRAM (340B) MEDICATIONS FOR FAMILY PLANNING, SEXUALLY TRANSMITTED INFECTION, AND TUBERCULOSIS

DATE DEVELOPED: 4/17
REVIEWED: 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. PURPOSE:

This document contains descriptions of the policies and procedures used at Rockingham County Health Department [also referred to in this document as the "covered entity" or "entity"] to maintain compliance with the 340B Program.

Rockingham County Health Department will provide medications for treatment/ control of TB and STIs. Contraceptives are provided to reduce unintended pregnancies and improve selected health practices among low income families.

II. DEFINITIONS:

Definitions of terms may be found in [Appendix: 340B Glossary of Terms, other entity specific definitions].

III. REFERENCES:

340B Glossary of Terms, OPA website, etc.

IV. POLICY REVIEW, UPDATES, AND APPROVAL:

This policy will be reviewed, updated and approved by Rockingham County Health Department Staff/Committee at least once every twelve months with documentation.

V. BACKGROUND:

Section 340B of the Public Health Service Act (1992) requires drug manufacturers participating in the Medicaid Drug Program to sign an agreement with the Secretary of Health and Human Services. This agreement limits the price manufacturers may charge certain covered entities for covered outpatient drugs. The resulting program is called the 340B Program. The program is administered by

the Office of Pharmacy Affairs (OPA), a part of the federal Health Resources and Services Administration/Department of Health and Human Services.

Upon registration in the OPA database as a participant in the 340B Program, entities agree to abide by specific statutory and prohibitions.

Rockingham County Health Department Division of Public Health Services purchases medications from the Federal Drug Pricing Program (340B) for the specific programs of Tuberculosis (TB), Sexually Transmitted Infection (STI), and Family Planning Birth Control (BC).

VI. 340B POLICY STATEMENTS:

As a participant in the 340B Drug Pricing Program, Rockingham County Health Department policies are:

1. Rockingham County Health Department uses any savings generated from 340B in accordance with 340B Program intent. The 340B program enables covered entities to stretch scarce resources as far as possible, reaching more eligible patients and providing more comprehensive services.

2. Rockingham County Health Department meets all 340B Program eligibility requirements.

    a. Rockingham County Health Department ensures that the agency's listing as a covered entity in the OPA Database is complete, accurate, and correct.
    b. Rockingham County Health Department receives a grant or designation consistent with that conferring 340B eligibility [Notice of Award from Title X is on file at NC DPH Women's Health Branch. In the event of HRSA audit, Rockingham County Health Department will contact the Family Planning and Reproductive Health Unit Manager to obtain a copy.]

3. Rockingham County Health Department complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity. [REFERENCE: Public Law 102-585, Section 602, 340B Guidelines, 340B Policy Releases]

4. Rockingham County Health Department maintains auditable records demonstrating compliance with the 340B requirement described in the preceding bullet.

    a. Prescriber is employed by the entity, or under contractual or other arrangements with the entity, and the patient receives a health care service (within the scope of grant/designation for which 340B status was conferred) from this professional such that the responsibility for care remains with the entity. Rockingham County Health Department will maintain a current prescriber list at all times. This list will include a description of the relationship between entity and prescribers and any supporting documentation, and the list will be updated at least every twelve months, and more frequently as providers change.
    b. Family Planning Entity maintains records of their patient's health care. Family planning documents within the Patagonia EHR system.
    c. If Rockingham County Health Department bills Medicaid for 340B drugs, billing follows state guidelines, and Rockingham County Health Department has reflected its information on the OPA website Medicaid Exclusion File.

Medicaid carve-in	340B entities may elect to use drugs purchased at 340B prices to bill for Medicaid it must indicate this on the Medicaid Exclusion File and list the appropriate Medicaid provider numbers or NPIs. Entities must inform HRSA whether they are carving in or out.
Medicaid carve-out	340B entities may elect to use non-340B drugs to bill for Medicaid patients. This activity is termed a "Medicaid carve-out." Entities may choose to do this so they can receive fair Medicaid reimbursement (many states reimburse entities that use 340B for Medicaid patients on a cost + dispensing fee basis, as the dispensing fee is often not high enough to cover costs). Entities must inform HRSA whether they are carving in or out through the Medicaid Exclusion File.

5. Rockingham County Health Department informs OPA immediately of any changes to its information on the OPA website/Medicaid Exclusion File.

6. Medicaid reimburses Rockingham County Health Department for 340B drugs per state policy, which states that "providers billing for 340B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under 340B purchasing agreement by appending the "UD" modifier on the drug detail." Medicaid does not collect rebates on claims from Rockingham County Health Department.

7. Rockingham County Health Department has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.

8. Rockingham County Health Department has an internal audit plan adapted by the internal compliance officer and conducted annually.

9. Rockingham County Health Department acknowledges its responsibility to contact OPA as soon as reasonably possible if there is any change in 340B eligibility or material breach by the Family Planning Entity of any of the foregoing policies.

10. Rockingham County Health Department acknowledges that if there is a breach of the 340B requirements, Rockingham County Health Department may be liable to the manufacturer of the covered outpatient drug that is the subject of the violation, and depending upon the circumstances, may be subject to the payment of interest and/or removal from the list of eligible 340B entities.

11. Rockingham County Health Department elects to receive information about the 340B Program from trusted sources, including, but not limited to:

    a. The Office of Pharmacy Affairs
    b. The 340B Prime Vendor Program, managed by Apexus
    c. Any OPA contractors
    d. NC State Pharmacist Consultant (who attends 340B University and OPA/HRSA trainings)

VII. RESPONSIBLE STAFF, COMPETENCY:

The following Rockingham County Health Department Staff are engaged with 340B program compliance. Pharmacy and other staff member(s) participating in the 340B Program complete initial training via webinar on the 340B and Prime Vendor Programs (https://www.brainshark.com/apexus/TopFive340BBasics) and the State Pharmacist will attend 340B University every 1-2 years. Comprehensive training is conducted on the 340B Program initially upon hire and competency is also verified annually by Pharmacy Manager through verbal assessment and as part of the staff development plan.

A. Authorizing Official is the Health Director Position
B. Primary Contact is the Director of Nursing

Guidelines

A. The Pharmacy Manager will keep a perpetual inventory system to control purchase, use, and for the reordering of medications and supplies.

B. The division of Public Health has adequate safeguards in place to ensure that supplies purchased through the 340B are provided only to clients. Prescriptions are only filled upon receipt of a written/electronic prescription from the clinic. No outside prescriptions are filled.

C. The pharmacy will operate in accordance with the federal and state laws relating to security and record-keeping for drugs and devices.

D. The inventory, supply, and provision of pharmaceuticals will be conducted in accordance with state pharmacy laws and professional practice regulations by the Pharmacy Manager.

VIII. 340B ENROLLMENT, RECERTIFICATION, CHANGE REQUESTS:

Recertification Procedure

OPA requires entities to recertify their information as listed in the OPA database annually. Rockingham County Health Department Authorizing Health Director annually recertifies Rockingham County Health Department information by following the directions in the recertification email sent from the OPA to the Authorizing Official by the requested deadline. Specific recertification questions should be sent to: 340b.recertification@hrsa.gov

Enrollment Procedure: New Clinic Sites

The Rockingham County Health Department evaluates a new service area or facility to determine if the location is eligible for participation in the 340B Program. The criteria used include: service area must be within the scope of the grant/designation received by the entity that confers 340B status, have outpatient drug use, and have patients that meet the 340B patient definition.

If a new clinic meets these criteria, the Rockingham County Health Department Authorizing Official completes the online registration process during the registration window (January 1 - January 15 for an effective start date of April 1; April 1 - April 15 for an effective start date of July 1; July 1- July 15 for an effective start date of October 1; and October 1- October 15 for an effective start date of January 1).
http://opanet.hrsa.gov/opa/CERegister.aspx?mode=mode=opf&isnew=true

Dispensing from a new clinical site may only occur after the agency has determined that the location is eligible for participation in the 340B Program AND has registered the new site with OPA.

Changes to Rockingham County Health Department Information in OPA Database Procedure

It is Rockingham County Health Department's ongoing responsibility to immediately inform OPA of any changes to its information or eligibility. As soon as Rockingham County Health Department is aware that it loses eligibility, it will notify OPA immediately and stop purchasing (or may be required to repay manufactures).

An online change request will be submitted to OPA by Rockingham County Health Department Authorizing Official for changes to Rockingham County Health Department's information outside of the annual recertification timeframe. Change form will be submitted to OPA as soon as the entity is aware of the need to make a change to its database entry. Change form shall be submitted for changes including, but not limited to physical address of the agency/clinic, mailing address of the agency/clinic, authorizing official or primary contact, etc.

IX. 340B PROCUREMENT, INVENTORY MANAGEMENT, DISPENSING

340B inventory is procured and managed in the following settings:

In-house Pharmacy

1. Entity uses either only 340B inventory, or electronically or physically separates 340B and non-340B purchased inventory. Pharmacists, technicians or designated clinical staff dispenses 340B drugs only to patients meeting all the criteria.

2. Entity staff places 340B orders from Cardinal Health through periodic inventory review and shelf inspections of PAR levels. APEXUS is a secondary wholesaler and used in the event of product shortages.

3. Entity Staff checks in 340B inventory by examining the Cardinal Health invoice against the order, and reports inaccuracies to Cardinal Health.

4. Entity stores 340B inventory securely and limits access to designated clinical staff.

5. Entity maintains Daily Prescription Log unless the entity chooses to combine the two into one log.

6. Entity documents in the inventory log each drug or device received. This documentation includes the following:

    a. A separate inventory page or electronic record for each drug/device with individual NDC#.
    b. A record of the date received, quantity received, lot# and expiration date.
    c. A record showing the addition of the quantity received to the expected inventory on hand.

7. Entity accounts for the amount of each drug or device dispensed within a designated timeframe, according to the NC Board of Pharmacy regulations.

    a. Dispensing logs are verified against the actual prescription orders by the pharmacist. Prescription orders must be accessible to the pharmacist and paper or electronic format. Prescriptions must be maintained for at least five years.
        i. Entities that dispense drugs to less than 30 patients per day required pharmacist to verify/sign the log weekly.
        ii. Entities that dispense drugs to 30 or more patients at a dispensing site within 24 hours require the pharmacist to sign the log within 24 hours of dispensing.
    b. The quantity of each item dispensed from the dispensing log is totaled and recorded under the appropriate column of your inventory log.
    c. Quantity dispensed should be deducted from the expected inventory on hand.

8. Entity conducts a physical count of the inventory on a **weekly** basis.
    - Entity staff physically counts the inventory of each drug/device and documents the count and date of the count in the appropriate column of the inventory sheet.

9. Entity compares the expected (theoretical) inventory with the actual (physical) inventory.

    a. Entity staff determines the expected inventory on hand accounting for all drugs/devices dispensed and received (See # 6-7)
    b. Entity staff determines the actual physical count of the inventory (See #8 above)

c. Entity staff compares the expected inventory to the physical count. Is the expected inventory equals the physical count there is no discrepancy. If the expected inventory is greater or less than the physical count a discrepancy exist - see step 10 below.

10. Entity staff creates an inventory discrepancy report (see Appendix II) when a discrepancy occurs and reports to Health Director or Director of Nursing.

11. Pharmacy Manager maintains records of 340B related transactions for a period of **five years** in a readily retrievable and auditable format (located in the pharmacy).

Step-by-step Instructions for Dispensing

1. A prescription is generated by the licensed practitioner or written by the RN under standing orders from the MD.

2. The prescription is filled by the pharmacist or an RN trained at dispensing medications using medication provided free of charge for BC, STI, or TB patients only. Family Planning medication is provided by the county.

3. A label is generated by the computer and placed on the prescription bottle containing the patient's name, the date, and directions for taking medication, the name and quantity of medication, the name of practitioner/provider, and the prescription number.

4. An audit copy of the label is produced that also contains the NDC number of the drug. This is placed on the back or front of the written prescription.

5. The patient is counseled on the use of the drug and signs the “patient counseled” sticker to be placed on the patient's chart.

340B Medications Administered to Clients/Patients

1. Drugs are pre-packaged by the pharmacist for use in the clinic to be administered to the patient by the RN.

2. Individual STI in drug dosage is packaged in the bottle, labeled with the drug name (generic and trade name if applicable), strength of drug, quantity of drug, NDC number, manufacturer’s number and expiration date.

3. Two labels are generated and placed on the bottle by the pharmacist. STI drugs are signed out from the pharmacy in multiple lots using “sign out book for STI” and taken to the clinic for secure storage.

4. The RN counsels patient on individual medication before administering the dose of STI medication in the clinic.

5. One label containing drug information is removed from the bottle and placed on the patient sign out sheet.

6. The other label is removed from the bottle and placed in the patient's chart and the patient's signature is recorded.

7. IUDs and Depo-medroxyprogesterone are signed out from the pharmacy in the sign out book by the RN and administered to the patient in the clinic. This is documented in the patient's chart.

8. The 340B sign out sheets are completed by the RN and placed in the 340B log book titled "Completed 340B Sheets" located in the pharmacy.

Inventory Control and Property Management

1. The Pharmacy Manager will keep an inventory log of all Title X devices and medications used in the Family Planning Clinic.

2. The RN will obtain single dose Depo-Provera and pre-packaged STD 340B meds from the pharmacy to maintain stock in the Family Planning/STD Clinic. The RN will sign out for the STD medication and Depo-Provera single dose units (150mg and 104mg) on the Drug Sign-Out Sheet for RN's located in the pharmacy. To complete the sign-out sheet, the RN will indicate the name of the drug, the date, the NDC number, lot number, the expiration date, quantity, and the RN's signature.

3. The RN will take the inventory and sign it into the 340B notebook kept in the clinic.

4. For Quality Assurance, upon return of the completed "Patient Drug Sheet" the pharmacist compares it to the "Drug Sign-Out Sheet for RN's" to verify for accuracy.

5. Weekly inventory is performed by Pharmacy Manager.

6. The Pharmacy Manager checks for out of date stock. Stock is rotated and as new stock arrives, the newest stock is placed in back.

7. Daily reports are reviewed/audited by the Pharmacy Manager.

8. Pharmacy will maintain a minimum of three month's supply of all commonly used STD drugs in the event of shortages.

X. REIMBURSEMENT

The Entity of teams reimbursement for 340B drugs for Medicaid according to Rockingham County Health Department policy. The state Medicaid reimbursement policy for NC is Clinical Coverage Policy 9 at http://ncdma.s3.amazonaws.com/s3fs-public/documents/files/9.pdf. This addresses any drugs that are administered. For contraceptive drugs or devices inserted or injected, if your agency has an outpatient pharmacy, use the DMA Clinical Coverage Policy 1B at https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1B.pdf.

Resources for 340B Medicaid information are:

HRSA website, Medicaid section
HRSA Medicaid Policy Release
FAQs (search on specific keyword)
DMA Physician Drug Program Policy
Apexus website

XI. RECOMMENDED MONITORING AND REPORTING

The entity uses the process outlined in: 340B Compliance Self-Assessment: Self-Audit to Ensure 340B Compliance.

Reporting 340B-Non-Compliance

Types of non-compliance that warrant a report to OPA/manufacturer - Each agency must establish its own definition of what constitutes a "material breach;" refer to the Establishing Material Breach Threshold Tool. [Information on self-disclosures and a template for reporting are available here: https://www.hrsa.gov/opa/updates/september2014.html.]

340B Compliance Review

The 340B Compliance Review summarizes activities necessary to ensure a comprehensive review of 340B compliance at Rockingham County Health Department. Rockingham County Health Department staff is responsible and accountable for overseeing this review process, as well as taking corrective actions based upon findings. The table below summarizes compliance activities and suggests the frequency with which those activities should be conducted.

Activity	Frequency (suggested)	Entity Eligibility	No Diversion	No Duplicate Discount
Review of all OPA database information for Rockingham County Health Dept, indigent care agreement with state/local government Entity Staff responsible: Pharmacy Manager	Annual			

Appendices Documents
340B Drug Inventory Form
Drug Sign Out Sheet for RNs
Inventory Discrepancy Report Template

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NALOXONE DISTRIBUTION

DATE DEVELOPED: 10/3/2017
REVIEWED: 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Rockingham County Division of Public Health (RCDPH) provides Naloxone kits to opioid users, family members, friends or domestic partners of active opiate users for the purpose of providing greater access to naloxone in order to reduce opiate overdoses

II. PURPOSE:

To clearly describe the process by which naloxone kits are provided directly by RCDPH to the opiate user, family, members, friends or domestic partners of active opiate users for the purpose of providing greater access to naloxone and reducing opiate overdoses.

Definition:

Naloxone (also known as Narcan) is a medication called an "opioid antagonist" which is used to counter the effects of opioid overdose.

III. GUIDELINES:

A. Standards for dispensing naloxone kits

1. Individuals 18 years of age or older who present to RCDPH and request naloxone will be directed to the pharmacy.
2. Clients who receive clinic services from a clinical provider and are assessed through a routine exam, to be in the need of a naloxone kit (self-report by client, obvious evidence of drug use) will receive education and a prescription from naloxone from the clinical provider.
3. Naloxone kits are dispensed by the RCDPH Pharmacy under a standing order issued by the North Carolina State Health Director or as prescribed by a RCDPH Clinical Provider.
4. Each kit contains:

    a. Two 2mg/2ml luer lock prefilled syringes
    b. Two 25g/1 inch needles

c. Two sets of latex gloves
d. Two alcohol pads
e. Printed material regarding overdose prevention and treatment, to include information at recognizing and responding to suspected opioid overdose and the importance of summoning emergency responders.

5. Each individual who requests a naloxone kit must receive screening and education from a RCDPH licensed pharmacist and/or a clinic provider before a kit is dispensed.
6. A clinical provider or Medical Provider will be consulted if any concerns about dispensing a kit arise during any part of the screening or education process.

B. When an individual presents to the RCDPH Pharmacy, the pharmacist will:

1. Screen the individual

a. Confirm that the individual is 18 years or older
b. Clarify that the individual who requests the kit has a personal need for it or is in a position to assist a family member, friend, or other person at risk of experiencing an opiate related overdose.
c. Verify that the individual reports no known sensitivity or allergy to naloxone hydrochloride.
d. Consult with a clinical provider or Medical Director if any concerns about dispensing a kit to an individual arise during any part of the screening or education process.

2. Educate the individual

a. Provide a brief description of what naloxone is and what it does when used as intended
b. Discuss possible side effects of naloxone such as:

- Chest pain, fast irregular heartbeats;
- Dry cough, wheezing, feeling SOB
- Sweating ,severe nausea or vomiting
- Severe headache, agitation, confusion, ringing in the ears;
- Seizure
- Slow heart rate, weak pulse, fainting, slow breathing

c. Note that these side effects may appear within minutes of naloxone administration and subside in approximately 2 hours

d. Describe the signs of an overdose

- Awake but unable to talk
- Body is limp
- Face very pale or clammy
- Fingernails and lips turn blue or purplish
- For lighter skinned people , the skin tone turns bluish purple; for darker skinned people, the skin turns grayish ashen
- Breathing slowed and shallow, erratic, or has stopped
- Pulse is slow, erratic, or not there at all
- Choking sounds, or snore like gurgling noise
- Vomiting
- Loss of consciousness
- Unresponsive to outside stimulus

e. Review how to respond to an overdose

- Call 911
- Administer from kit
- Remain with the person until EMS (911) arrives
- Initiate rescue breathing if needed

f. Verify individuals understanding of information provided

3. Dispense a naloxone kit

a. Review and explain all items in the naloxone kit to the individual

- Two 2 mg/2ml prefilled syringes of naloxone hydrochloride
- Two 25g/1 inch needles
- Two sets of latex gloves
- Two alcohol pads
- Printed materials regarding overdose prevention and treatment, to include information regarding recognizing and responding to opioid overdose and the importance of summoning emergency responders

b. Demonstrate/simulate to the individual how to correctly use items in the kit

- Remove naloxone from box
- Remove protective caps from vial and injector

- Thread vial into injector 3 half turns, or until stopper is pierced by metal cannula
- Remove cover and expel air
- Connect needle to luer lock syringe
- Don gloves
- Clean the shoulder or thigh with the alcohol pad
- Call 911
- Administer the entire contents of the syringe into the thigh or shoulder
- Monitor respirations and responsiveness of the recipient
- Repeat every 3 minutes as needed if no or minimal response

c. Explain that there is an expiration date on the end of the box and do not use past the expiration date

4. Follow Up and Referral

After dispensing the kit, the pharmacist will

a. Complete Naloxone Kit Medication and Education Distribution Log
b. Ensure all items on the naloxone screening checklist were discussed with the individual
c. Instruct the client/patient to call RCDPH Pharmacy at 336-342-8193 if there are any questions or concerns on how to use the kit
d. Encourage individual to communicate with primary care provider regarding overdose, use of naloxone, and availability of behavioral health and substance abuse services
e. Provide referral for Behavioral Health Services
f. Refer as needed for other HD services
g. Provide the kit with no charge to the recipient

C. Clinical Setting

1. Clients who receive clinical services and are assessed by a provider through routine exam, to be in need of a naloxone kit (self- report or clinical evidence of drug use) will receive education from the clinical provider as outlined in Guidelines, Section B1.
2. After providing education

a. Write a prescription for the naloxone and direct to the pharmacy. If it is a day/time the pharmacist is not present retrieve naloxone from the pharmacy and dispense to the client.
b. Provide all required education and referral information

c. Document all care and services in the clients electronic medical record

Appendices:

1. Appendix A: Pharmacy –Naloxone Screening Checklist
2. Appendix B: RCDPH Behavioral Health Referral Form
3. Appendix C: RCDPH Naloxone Kit Medication and Education Distribution Log
4. Appendix D: North Carolina State Health Director's Standing Order for Naloxone

References and Resources:

1. Session Law 2103-23, NC Senate Bill 20
2. North Carolina State Health Director's Standing Order for Naloxone
3. NC GS 90-96.2, Drug-related overdose treatment; limited immunity
4. NC GS 90-106.2, Treatment of overdose with opioid antagonist; immunity

/di

Appendix A

Pharmacy - Naloxone Screening Checklist

☐ Confirm individual is 18 years of age or older, knows someone or self-reports he/she takes prescription pain medication such as Oxycodone, (Oxys or Roxys), Hydrocodone, Fentanyl, Methadone, or uses Heroin.

☐ Explain what naloxone does when used correctly; discuss possible side effects of naloxone

☐ Explain/describe signs of an overdose

☐ Educate on how to respond to an overdose

☐ Stress the importance of calling 911 in overdose situations

☐ Stress the importance of staying with the person until help arrives

☐ Review all items in the naloxone kit

☐ Play video or demonstrate how to administer naloxone and perform rescue breathing

☐ Encourage opioid user to communicate with primary care provider regarding use of naloxone

☐ Refer individual for other needed services (i.e., Adult Health, Immunization Clinic, Family Planning, other providers, etc.)

☐ Provide Behavioral Health referral

☐ Ask if individual has other questions, concerns

Appendix B

1-800-939-5911

24 Hour Referral and Crisis Line

Substance Use Provider	SUD Population / Services (SUD, Others)
Daymark Recovery Services 405 NC Highway 65N Wentworth, NC Phone: (336) 342-8316	Adult SUD / Assessment, Outpatient, Medication Management, Assertive Community Treatment Team, Community Support Team, Mobile Crisis Management, Psychosocial Rehabilitation, other services available **Medication Assisted Treatment (Suboxone) and detox services pending, October 2017
NOTE: Daymark & Insight Human Services collaborate to provide an evidence-based Medication Assisted Treatment (medication & clinical services)	
Youth Haven Services 229 Turner Drive Reidsville, NC Phone: (336) 314-2233	Adolescent SUD and Adult SUD/ Assessments and Outpatient Counseling Services, Medication Management; please contact provider for other available services
Insight Human Services 405 NC Highway 65 Reidsville, NC Phone: (336) 342-8316	Adolescent SUD and Adult SUD / Assessment, SUD Intensive Outpatient Program and Counseling Services; please contact provider for other available services
NOTE: Daymark & Insight Human Services collaborate to provide an evidence-based Medication Assisted Treatment (medication & clinical services)	
Linda McRae HOPE Counseling & Consulting 460 Salem Church Road Reidsville, NC Phone: (336) 624-2347	Adult SUD and Adolescent SUD/ Assessment, Outpatient services, free problem gambling services; please contact provider for other available services
James Burston, LCAS Burston's Consulting & Counseling Services 1117 S. Main St Reidsville, NC Phone: (336) 613-5515	Adult SUD and Child SUD / Assessment, Outpatient Counseling; please contact provider for other available services
REMMSCO 108 North Main St Reidsville, NC Phone: (336) 342-9504	Adult SUD / Substance Abuse Services Halfway House (Planned admission)
TRIAD BEHAVIORAL RESOURCES, NEW VISION THERAPY & DR. MARK SCHEUTZOW 232 Gilmer St, Suite 202 Reidsville, NC Phone: (336) 389-1413	Adult SUD / Assessment, Outpatient Counseling, Medication Assisted Treatment (including Suboxone); please contact provider for other available services
Sharon Dockery Resolution: Counseling & Developmental Services 7490 NC-87 Reidsville, NC Phone: (336) 349-8848	Adult SUD and Child SUD / Assessment, Outpatient Counseling, Licensed DWI Facility; please contact provider for other available services
Rockingham County Youth Services 335 County Home Road Reidsville, NC Phone: (336) 342-5756	Adolescent Substance Abuse Prevention Education; please contact provider for other available services
Genesis Ministries of Rockingham County PO Box 4564 Eden, NC 27289 Phone: (336) 344-2525	Genesis Ministries exists to provide a new beginning for individuals who are bound by addiction. Through instructions, modeling, and a Christ centered atmosphere students will be set free to live healthy spiritual, physical, mental and emotional lives. Please contact the program for additional information concerning services.

This information is subject to change at any time and verification with Cardinal is preferred.

Appendix C

Naloxone Kit Medication and Education Distribution Log

Date	Clinic Provider	Pharmacist Name	**Naloxone Kit Prescription Information** *Verification of Medication, Behavioral Referral and Education*	
			Patient Education and Behavioral Health Referral Received (initial below)	Naloxone Kit and Counseling received from Pharmacist (initial below)
Date	Clinic Provider	Pharmacist Name	**Naloxone Kit Prescription Information** *Verification of Medication, Behavioral Referral and Education*	
			Patient Education and Behavioral Health Referral Received (initial below)	Naloxone Kit and Counseling received from Pharmacist (initial below)
Date	Clinic Provider	Pharmacist Name	**Naloxone Kit Prescription Information** *Verification of Medication, Behavioral Referral and Education*	
			Patient Education and Behavioral Health Referral Received (initial below)	Naloxone Kit and Counseling received from Pharmacist (initial below)

Appendix D

North Carolina State Health Director's Standing Order for Naloxone

This standing order signed by the North Carolina State Health Director authorizes any pharmacist practicing in the state of North Carolina and licensed by the North Carolina Board of Pharmacy to dispense the following Naloxone products to persons as directed below.

<table>
<tr><th colspan="4">Naloxone HCl Dispensing Protocol</th></tr>
<tr><td>Eligible Candidates</td><td colspan="3">▪ Persons who voluntarily request Naloxone and are at risk of experiencing an opiate-related overdose, including, but not limited to:
– Current illicit or non-medical opioid users or persons with a history of such use
– Persons with a history of opioid intoxication or overdose and/or recipients of emergency medical care for acute opioid poisoning
– Persons with a high dose opioid prescription (>50 morphine mg equivalents per day)
– Persons with an opioid prescription and known or suspected concurrent alcohol use
– Persons from opioid detoxification and mandatory abstinence programs
– Persons entering methadone maintenance treatment programs (for addiction or pain)
– Persons with opioid prescription and smoking/COPD or other respiratory illness or obstruction
– Persons with an opioid prescription who also suffer from renal dysfunction, hepatic disease, cardiac disease, HIV/AIDS
– Persons who may have difficulty accessing emergency medical services
– Persons enrolled in prescription lock in programs
▪ Persons who voluntarily request Naloxone and are the family member or friend of a person at risk of experiencing an opiate-related overdose.
▪ Persons who voluntarily request Naloxone and are in the position to assist a person at risk of experiencing an opiate-related overdose.</td></tr>
<tr><td>Route(s) of Administration</td><td colspan="2">Intranasal (IN)
Preferred method</td><td>Intramuscular (IM)
Inject into shoulder or thigh</td></tr>
<tr><td>Medication and Required Device for Administration</td><td>Naloxone HCl 1 mg/mL Inj.
2 x 2 mL as pre-filled Luer-Lock syringes
▪ Dispense 2 (two) doses
2 (two) x Intranasal Mucosal Atomizing Devices (MAD 300)
Available from: Teleflex (866-246-6990) or Safety Works, Inc. (800-723-3892)</td><td>Narcan ® 4 mg/0.1 mL Nasal Spray
▪ Dispense 1 x two-pack</td><td><u>Naloxone HCl 0.4mg/mL Inj.</u>
▪ 2 x 1mL single dose vials (SDV)
▪ 2 (two) 3 mL syringe
▪ 2 (two) 25 G, 1 inch needle

<u>Naloxone HCl 2 mg/2mL Inj.</u>
▪ Dispense 2 (two) pre-filled syringes
▪ 2 (two) 25 G, 1 inch needle</td></tr>
<tr><td>Directions for Use</td><td>Call 911. Spray 1 mL in each nostril. Repeat every 3 minutes as needed if no or minimal response.</td><td>Call 911. Administer a single spray of NARCAN® in one nostril. Repeat every 3 minutes as needed if no or minimal response.</td><td>Call 911. Inject the entire solution of the vial or pre-filled syringe IM in shoulder or thigh. Repeat every 3 minutes as needed if no or minimal response.</td></tr>
<tr><td>Refills</td><td colspan="3">PRN</td></tr>
<tr><td>Contraindications</td><td colspan="3">A history of known hypersensitivity to Naloxone or any of its components</td></tr>
<tr><td>Patient Education</td><td colspan="3">Every person dispensed Naloxone under this standing order shall receive education regarding the risk factors of overdose, signs of an overdose, overdose response steps, and the use of Naloxone. Examples of educational materials that incorporate the above information may be found at http://www.naloxonesaves.org.</td></tr>
<tr><td>Notification of Participation</td><td colspan="3">Pharmacies choosing to participate in Naloxone distribution under the authority of this standing order shall notify the Division of Public Health when initiating their participation; see directions for notification at http://www.naloxonesaves.org.</td></tr>
</table>

Elizabeth C. Tilson, MD, MPH
National Provider ID: 1760540421

August 16, 2017
Date

This order is effective immediately upon signing and may be revised or revoked by the State Health Director according to his/her discretion.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Pharmacy Orientation Checklist

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A. Division of Public Health Services 1. Mission, vision, goals 2. Location and Review of policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B. Review of Policies: 1. Agency Safety – HIPAA – P&P - Sign and Date a. Fire Prevention and Plan b. Smoke Sensors c. Fire Extinguishers d. Exit Signs e. Security f. Tornado Plan g. Emergency Preparedness i. Pharmacy Disaster Training ii. Pharmacy Disaster Assistance iii. Emergency Shelters and Team Assigned		
2. Personal Safety a. Agency Worksite b. Vehicle Safety c. Threatening Behavior d. Medical Emergencies i. Clients ii. Employees iii. Staff training for • HIPPA • Cultural Diversity • Body Mechanics		

3. Infection control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease d. Precautions e. Cleaning, Disinfecting, Transporting Equipment f. Storing and Handling Supplies g. Standard Precautions h. Blood Borne Pathogens i. Vaccinations • TB Skin Test • Hepatitis B or Waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management • Vaccine Transporting, Handling & Storage k. Identifying, Handling, and Disposing of Hazardous Materials l. Safety Data sheets m. Personal Protective Equipment • Disposal of needles • Gloves • Impermeable gown • Vent Mask • Antibacterial Hand Wash • Spill kit • N-95-Respirator Mask • Goggles/Face Shield		
4. Community Resources and Collaboration		
5. Continuing Education requirements		
6. Employee Performance Evaluation		
C. Improving Organizational Performance Measures 1. IOP Committee and Purpose 2. Call supervisor by 7:00am if not reporting to work 3. Job Description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Quarterly Audits if applicable c. Incident Reports d. Blood Borne Pathogen Exposure e. Client Complaints		
D. Preceptor Assigned – works well with and under direction of preceptor		
E. Orientation Period – write in dates		
F. Program Area		

1. Introduction to work area
2. Introduction to program and guidelines state/ federal/local
3. Work Schedule – M-F and on-call (if applicable)
4. Pager system
5. Scope of services and program policy review
6. Client Medical Record
   a. Charting System – Review POHR Manual
      - Problem list – A sequential listing of problems identified during each visit. Documentation may reflect diagnoses, symptoms, psychological conditions, and abnormal test results, environmental, occupational or economic conditions, which may compromise the client's health. Also indicate when problems are resolved.
      - Initial Assessment – Written on "notes". This is a plan devised to deal with each problem. Each assessment and plan is correlated to the number of the problem on the problem list
      - Progress Notes – A record of the clients care. Entries are correlated to the number of the problem identified. Notes are written by everyone serving the client
      - SOAP format
        - Subjective
          Information reported by the client, the client's family, or another person. It may include the client's history, physical, social, emotional, mental, spiritual and economic information
        - Objective
          Information that is described, measured, observed, and verifies. Something you can see, hear, feel, smell, count, etc. Ex: Physical exam, lab test, wt, vitals, etc.
        - Assessment
          To document a narrative progress note. An analysis, interpretation, or conclusion about the client's condition. Ex: Nursing diagnoses, interpretation, and evaluation of the problems. **This is where you chart opinions, judgment, interpretation, and analysis
        - Plan
          This identifies what you need to do for the client or what you are going to do for the client. Ex: Need more information, tests, need follow-up-management of, need education
   b. Chart Room – and procedure for retrieval
   c. Pharmacy documentation
      - How to correct entries
      - Writing neat and legible

• Most recent note on top • How to obtain physician's orders • Standing orders • Medication forms • Lab reports • Consent forms/Release of Information • Consent to photograph • Agency approved abbreviations • Client referral form • Follow-up of abnormal findings • Encounter form 7. Documentation tips a. Neat and legible entries using good grammar, spelling and punctuation b. Notes are signed, titled, and dated c. When teaching, chart what was taught, to whom it was taught, any return demonstrations, and client/caregiver's understanding d. Identify chief complaints to correlate with client's presenting symptoms e. Identify client diagnoses that correlate with problems evidenced and list on problem list. Keep problem list current f. Use quotes or the client's own words, Chart FACTUAL, ACCURATE, COMPLETE and TIMELY g. Document the name of interpreter used h. Put name and ID # on each page i. Date all entries – some may require time also j. Always use black ink k. Use only agency-approved abbreviations l. Do not write in margins m. Document signs, symptoms and observation related to the physiology and course of the disease process n. Includes the following information when analyzing a symptom: onset, predisposing factors, characteristics, location of pain, intensity, severity, aggravating or relieving factors, associated symptoms, course since onset, incidence and effect of therapy. Key words to use: unstable, deteriorating, improving, change in, learning, taught, instructed, observed, evaluated, new problem, concerned about, complains of, needs assistance with, monitored o. Educate clients on-going to the services and requirements of program		
8. Documentation don'ts a. Don't get personal, don't use derogatory references, don't keep secrets b. Don't cross out, squeeze or write in information at a		

later date c. Don't chart your own personal judgments d. Identify in your notes what physician was seen by the client; identify what physician you contacted, etc. Don't write "MD NOTIFIED" e. Do not use sticky notes on the chart f. Do not redo a page to eliminate errors or to put in late entries. Late entries should include two dates – the date care was provided and the date the entry was made		
9. Expectations of the Pharmacy Staff a. Report to work-site as assigned in a timely manner b. Use appropriate communication skills c. Document and enter data appropriately d. Accounts for all work hours through sign-out sheets, leave records, time sheets and mileage sheets e. Reviews and updates job description annually f. Adheres to dress code displaying a professional appearance or worksite appropriate attire g. Establishes an effective working relationship with others h. Reliable in following procedures/policies i. Provides nursing services to clients according to standard, program guidelines and collaborates with other health care disciplines j. Treats public with courtesy and respect k. Maintains complete confidentiality of client information l. To complete a client assessment for pharmacy purposes m. To obtain agency documented history of client n. To establish and prioritize a client specific problem list o. Collaborate with interdisciplinary teams or other agency programs to ensure the client's care is continuous and meeting their needs p. To utilize agency client clinical records q. Appropriate measures to receiving, storage, handling and labeling of all drugs r. Appropriate measures to remove and document outdated and recalled medications and appropriate removal procedures s. Works within the guidelines of a public health department pharmacy and maintain compliance with state and federal regulations		
10. Accreditation process-development, implementation and maintenance		

Employee Signature: _____ Date: _____

Supervisor Signature:_____ Date:_____

* When completed the supervisor will file.

* The Orientation Checklist should be completed at the end of the employee's probationary status.

Date Developed: 12/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 10/05; 1/06; 6/14

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Pharmacist/Pharmacy Staff

Competency Skills Checklist

		SUBJECT	DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The Pharmacy staff applies theoretical concepts in practice.						
	B.	The Pharmacy staff systematically collects data that is comprehensive and accurate.						
	C.	The Pharmacy staff evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	D.	The Pharmacy staff observes and records any reactions to treatment or changes in the client's condition and reports to appropriate prescriber.						
	E.	The Pharmacy staff participates in peer review and program audits to assure quality of services.						
	F.	The Pharmacy staff collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	G.	The Pharmacy staff reports to Pharmacy as assigned in a timely manner.						
	H.	The Pharmacy staff introduces self to client.						
	I.	The Pharmacy staff uses appropriate communication techniques to make client comfortable, addresses client concerns and telephone calls with dignity and respect.						
	J.	The Pharmacy staff performs the work-up of clients, accurately documenting results of information obtained.						
	K.	Pharmacy staff facilitates the flow of clients through the Pharmacy to promote health care accessibility, decrease wait time, and provide high quality services.						
	L.	Pharmacy staff demonstrates familiarity with the client record and chart composition.						
	M.	Pharmacy staff effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	N.	Pharmacy staff demonstrates support of agency by involvement in community activities.						
	O.	Pharmacy staff uses chain of command for problem resolution.						
	P.	Pharmacy staff adheres to appropriate dress and grooming.						
	Q.	Pharmacy staff maintains a reliable attendance record.						
	R.	Pharmacy staff safely and accurately assists other staff during procedures.						
	S.	The Pharmacy staff will thoroughly demonstrate: 1. promotion and maintenance of health 2. prevention of illness and disability 3. guidance and counseling for both individuals and families 4. planning for situations beyond the Pharmacy Staff's expertise and consulting with and referring to other health care providers as appropriate, and						

		5. Quality Improvement for Pharmacy Staff a. The Pharmacy Staff will follow a written plan for evaluating the quality of care in conjunction with the supervising Pharmacist. b. This plan may include scheduled meetings with the Pharmacist and Physician Extender c. This plan will be documented identifying clinical problems, progress toward improving outcomes and recommendations for changes in treatment plan.							
	T.	Accurately records client encounter.							
	U.	Documentation must be timely, accurate and precise.							
	V.	Maintain licensure and continuing education requirements.							
	W.	Adheres to agency policies and procedures - reviews annually							
	X.	Reports any changes in client status.							
	Y.	Demonstrates ongoing communication with the client and professional staff.							
	Z.	Properly completes all required documentation on assigned clients within a timely manner using correct medical terminology.							
	AA.	Knowledgeable and maintains client rights and confidentiality.							
	BB.	Implements measures to maintain client confidentiality.							
	CC.	Demonstrates understanding and implementation of HIPAA compliance.							
II.		**Safety:**							
		1. Employee demonstrates appropriate hand hygiene. 2. Employee demonstrates knowledge and implementation of proper body mechanics and OSHA requirements. 3. Employee demonstrates knowledge of Emergency policies/ protocols.							

_____ successfully demonstrates the above criteria in the clinical setting.

_____ _____
Employee Signature & Date Reviewer's Initials & Date

_____ _____
Employee Signature & Date Reviewer's Initials & Date

_____ _____
Employee Signature & Date Reviewer's Initials & Date

Developed: 3/02
Reviewed: 6/13; 6/14; 6/15; 6/16; 6/17; 6/18; 6/19; 10/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 10/05; 6/14; 6/18; 10/19

The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

PREGNANCY CARE MANAGEMENT PROGRAM POLICIES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CARE MANAGEMENT FOR HIGH RISK PREGNANCIES (CMHRP)

DATE DEVELOPED: 4/11
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24

I. POLICY:

The Division of Public Health Services will provide or assure the provision of Care Management for High Risk Pregnancies (CMHRP) services to Medicaid eligible pregnant and postpartum women who reside in Rockingham County. CMHRP services will be provided in accordance to the Care Management for High Risk Pregnancies Standard Plan *(see attached)*. Current standardize plan is available at the Women's Health Branch website.

II. PURPOSE:

Care Management for High Risk Pregnancies (CMHRP) is outcome-focused, with an emphasis on improving birth outcomes through reducing the rate of preterm and low birthweight births and monitors the pregnant Medicaid population and prenatal service delivery system using data. CMHRP applies systems and information to improve care and assist members in becoming engaged in a collaborative process designed to manage medical, social and behavioral health conditions more effectively.

III. GUIDELINES:

HOURS OF OPERATION**:**

Normal hours of operation are Monday thru Friday, 8 a.m. until 5 p.m. Exceptions are county holidays and adverse weather when the health department may be closed or delayed. Scheduling may be necessary after 5 p.m. or weekends to accommodate clients with supervisor's awareness or in times of disaster or a public health emergency.

A. Risk Indicators:

Provide or assure the provision of Care Management for High Risk Pregnancies (CMHRP) services to Medicaid eligible patients, in accordance with CMHRP program requirements. With the onset of Medicaid Managed Care, local health departments are subcontracted by PrePaid Health Plans (PHP) to provide CMHRP services. The CMHRP population is comprised of PHP Priority Members and individuals who are eligible for services. Each PHP uses an internal, proprietary algorithm to determine their members who would benefit from intensive CMHRP services. The individuals identified as PHP Priority Members must receive CMHRP

services through pregnancy and the duration of their postpartum period. Individuals identified as eligible for CMHRP services include: A Maternal Infant Impactability Score (MIIS) of 200 or greater, provider request, care manager professional judgement, community referral, and self-referral or hospitalization ADT reports. The PHP Priority population is the focus on CMHRP services; however, individuals who are eligible for CMHRP services should receive intensive care management services until needs are met. Individuals who are not aligned with a PHP but receive Medicaid Direct and Presumptive Eligibility (PE) coverage should also be referred to CMHRP services as applicable.

B. Enrollment:

1. Pregnant women who receive Medicaid or who have applied for presumptive Medicaid are eligible for this service and services are covered during pregnancy and through the end of the month in which the 60th postpartum day occurs.
2. Referral requests may be received in person, via fax, email, VH notification, OB ADT, VH OB Queue, or by telephone call. They are given to program supervisor or nurse for assessment/ assignment.
3. Confidentiality of client information will be followed per agency policy.
4. The pregnant client should be referred to WIC services after initial contact by the care manager, if client is not already enrolled.
5. Referrals are made for Medicaid eligibility determination or completion of presumptive eligibility when care manager makes contact with a patient/client.
6. During enrollment the care manager must:

    a. Assign Episode Status *(See attached Standardized Plan)*
    b. Complete CNA – OB.
    c. Open care plans and goals based on reason of referral and/or identified needs of client and follow up as indicated.
    d. Assign an engagement level *(See attached* S*tandardized Plan page 13).*
    e. Complete interaction.
    f. Resolve any tasks associated with interaction.

C. Assignment of Pregnancy Care Managers:

1. Pregnancy Risk Screenings (PRS) and Medicaid PHP referrals are received and reviewed by the program supervisor or nurse and then assigned to CMHRP if determined to be priority or eligible for service. The program supervisor or nurse will assign a care manager to client/patient based on need, location, and availability of staff. The CMHRP supervisor or designee will assess OB Queue to identify CMHRP hospital usage and community referrals. Those

patients, if eligible, will be assigned to a care manager following same protocol as risk screens.

2. Referrals and assignments are entered into the Virtual Health (VH).
3. The CMHRP program will promote customer friendly services that meet the needs of populations that are underserved. An interpreter will be utilized to serve limited English proficiency clients.
4. All care managers and CMHRP supervisor will have direct access to the internet and email so they may participate in Women's Health Branch list serves, use VH, and access other technical resources and maternal health materials.
5. Staff will have increased awareness of disparities in health status and service delivery, especially related to race/ethnicity, disability, and socioeconomic status through annual trainings and workshops, review of policies annually and at orientation.

D. Tracking:

Initial Contact & Subsequent Contacts:

1. Initial contact or 3 attempted contacts shall be made by face-to-face or phone contact by care manager assigned to the client within seven (7) business days.
2. Subsequent contacts may be by face-to-face, video conferencing or phone contact. For enrolled patients a face-to-face phone call and/or video conferencing contact should be made at least every 30 days. Video conferencing may be used with patient consent and through a secure platform.
3. All contacts should be made in a private and HIPPA compliant manner.
4. Texting may be used with prior consent of the patient. Texting must not contain any protected health information and is not used in place of an approved patient-centered interaction (i.e., face-to-face, phone call or video conference**).**
5. Care management engagement levels will be assigned to patient/ client by care manager to determine follow-up/intensity/frequency of visits:

    a. High - Daily to weekly engagement with the member (at least every 7 days)
    b. Medium - Weekly to bi-weekly engagement with the member
    c. Low - Bi-weekly to monthly engagement with member (at least every 30 days)
    d. Pending/**Referred** - Newly identified client assigned to CMHRP awaiting screening. This status should not exceed 30 days unless outreach efforts are close to recurring contact and engagement and documentation reflects ongoing attempted contacts.

e. Closed - Client declined services, is non-compliant to care plan, does not meet criteria or inability to contact client after 5 attempts have been made, on 5 different occasions or a non-PHP priority patient with needs met. Outreach to the patient/client's medical home should be completed prior to closing as unable to reach.

See" Care Management for High Risk Pregnancies Standardized Plan" page 14 for closure definitions.

E. Collaboration of Agencies:

1. The care manager will contact the Pregnancy Medical Home (PMH) and any other agencies to obtain the services needed for client/ patient. Care manager will work with the patient and PMH to assure appointments with PMH are kept. PMH may contact CMHRP supervisor or care manager to obtain or share information pertinent to client/patient welfare. The care manager receiving information on the outcome of the home visit for Postnatal Assessment and Follow-up Care shall document this collaboration in the patient's care management record in VH, including any progress towards the patient's goals, noting that the services were provided by the nurse completing a home visit for postnatal assessment and follow-up care.

2. CMHRP care manager will collaborate with any assigned complex care managers. See attached S*tandardized Plan* page 11 for specific guidance.

F. Records:

1. Composition and Organization

a. Goals and Care Plans (reviewed **at least** every 30 days for high, medium, or low status; 90 days for intermittent)
b. CNA – OB (updated at least every 30 days)
c. Interactions
d. Tasks (chart should have no past due tasks and a patient pending task should be set)
e. Any needed documents uploaded to medical records section of VH.

2. Documentation

a. Must be in VH. Must be complete within 72 business hours of contact.

b. The Care Manager may provide education or make referrals for the following based on individual needs of clients/families:
   - Pediatrician selection
   - Premature rupture of membranes
   - Smoking cessation counseling using the 5 A's
   - Education on infant feeding including benefits of breast feeding and risks of not breast feeding
   - Childbirth education
   - Family Planning Services
   - Postpartum-Newborn Home Visit
   - Parenting classes
   - Postpartum check-up
   - Back to sleep and safe sleep counseling, and
   - Nutrition consultation to all obese women with a pre-pregnancy BMI >30 as indicated by provider or CMHRP

c. The 5 A method for tobacco cessation may be provided for all pregnant and postpartum women using the 5 A's (ask, advise, assess, assist, arrange) as recommended by ACOG and a referral made to the appropriate community resources.

d. CMHRP supervisor, CMHRP Care Manager and SIDS Counselors will have active electronic mail membership and direct access to the internet. HMHC funds can be used to finance and maintain hardware, software and subscription linkage to current local market values. The internet connection enables participation in Women's Health Branch list serves, use of Virtual Health (VH) documentation system, Care Impact, and access to other technical resources and to maternal health materials.

G. Transfer:

The client may elect to continue CMHRP services from another provider should they move to another North Carolina county. *(See attached Standardized Plan page 12 for procedure.)*

H. Discontinuation of CMHRP:

CMHRP services can be discontinued for the following reason(s):

1. Services are terminated at the end of the month in which the 60th postpartum day occurs.
2. Client states she no longer wishes to receive services.
3. Client is lost to follow-up after 5 attempts to contact/locate.
4. Client expires during the eligibility period.
5. Client becomes ineligible for Medicaid.

6. Client moves out of state.
7. Client is non-PHP priority and her needs have been met.

I. Transition:

The care manager may provide follow-up services to the mother and infant when transitioning the family to the Care Management for At Risk Children if a risk is identified. The care manager will follow the guidance in the most current Division of Medical Assistance CMHRP Policy.

J. Closure:

It is expected that the CNA-OB is updated with the most recent findings, all interactions have been submitted, and the member's pregnancy care management needs have been met. The Care Manager will complete steps 1-4 below:

1. Visit the Member's Care Plan

   a. Proceed to the Care Goal. Review and update member's "Progress" and "Status." Select appropriate responses from the drop down.
   b. Review "Problem Status" and select "End Date."
   c. Save the Care Plan.
   d. Sign the Care Plan.
   e. Document the member's signature or agreement with the care plan.

2. Update the Episode Status

   a. If the care manager is ending the episode because the postpartum needs have been addressed, set each "Problem Status" on the care plan to "Graduated" as appropriate; the Episode Status should automatically update to Graduated.
   b. If the episode is closing because the member has declined further care management services, set each "Problem Status" on the care plan to "declined" and click the check box on the care plan to indicate that "member has opted out of care management". This will update the Episode Status to "declined".
   c. If the member cannot be reached to engage in services, document by using the "unable to reach" box on the Member Profile. The Episode Status will update automatically.
   d. If the member has been lost to follow-up after engaging in Care Management services, set each "Problem Status" on the care plan to "Lost Contact", then document using the "unable to reach" box on the Member Profile. The Episode Status will update automatically.

e. Episode Status should be assigned manually as "ineligible", if the patient does not meet priority criteria and has no other care management needs or has lost Medicaid coverage.

K. Quality Assurance:

1. CMHRP Supervisor will review reports in Virtual Health (VH) and Care Impact to assure quality of services.

2. The Regional Social Work Consultants (RSWC) conduct performance monitoring and quality assurance activities for CMHRP services. These activities include: oversight of performance through the review of county reports generated from administrative and care management VH data, chart reviews, and site visits for performance review.

3. Chart review tool will be completed on a quarterly basis. These can be completed by supervisor or peers.

L. Caseload Size:

Caseload size will be monitored according to intensity level and number of clients/patients on CMHRP caseload.

M. Staff Qualifications:
Qualifications for the CMHRP will be per the most current Division of Medical Assistance CMHRP Clinical Policy. Qualifications may also be found in the most recent Division of Public Health Agreement Addendum (101-Maternal Health).

N. Staff Requirements:

1. Any changes in CMHRP Care Manager or CMHRP supervisor positions shall be electronically submitted to http://childrenyouth.staffing.sgizmo.com/s3/ as soon as possible. However, the changes must be submitted no later than 7 days after the staff change including hiring new staff, position vacancy, position elimination, or other staff changes. Additionally, the WHB Regional Social Work Consultant shall be notified of new staff as soon as possible but no later than 7 days after hire date.

2. In the event of a staff vacancy or an extended absence, the Contingency Plan for Staff Absence or Vacancy Form found in the Program Manual must be completed and submitted as outlined in the form instructions. The LHD shall maintain a contingency plan for any extended staff absence or vacancy to ensure that patients can access care management services in a timely manner and that there are no interruptions in service delivery. An extended staff absence is defined as longer than two weeks.

3. Interruption of services or inability to meet quality assurance deliverables must be reported as soon as possible (but no later than 7 days) the WHB Regional Social Work Consultant.

4. **Degree Requirements:**

   a. **Registered Nurse, or**
   b. **Social Workers with a:**

   - **Bachelor of Social Work (BSW, BA in SW, or BS in SW) or Master of Social Work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education (CSWE) accredited social work degree program; or**

   - **Bachelors Degree in a human service field with 3 or more years of care management/case management experience working with the specific population (low income, pregnant individuals and/or children ages 0-5 years) and has certification as a Case Manager (CCM preferred); or**

   - **Bachelors Degree in a human service field with 5 or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children ages 0-5 years.**

5. All new CMHRP Care Managers are required to complete the CMHRP orientation as outlined in the CMHRP New Hire Orientation Checklist located in the CMHRP Program Manual, adhering to the specific timeframes in the document.

O. Civil Rights:

1. The CMHRP Program is provided solely on a voluntary basis for those persons identified with having risks.

2. Acceptance of the CMHRP Program is not a pre requisite to eligibility for or receipt of any other program/service involvement or benefits.

3. No person on the grounds of race, color, age, religion, sex, creed, national origin, political affiliation, or physical handicap will be denied benefits or services.

The Care Management for High-Risk Pregnancies (CMHRP) Standardized Plan outlines methods and standards for CMHRP care managers (CM) to follow, working together with the Pregnancy Management Program (PMP) providers, with the goal of improving the quality of maternity care, improving birth outcomes and providing continuity of care for pregnant individuals who are eligible for Medicaid.

Local health department staff use VirtualHealth and CareImpact to assess the impact of CMHRP; therefore, it is *imperative* that CMs utilize the standardized processes defined in this plan and document their involvement and all activities with individuals receiving CMHRP services in a consistent manner across the state.

What is Care Management for High-Risk Pregnancies?

Care Management for High-Risk Pregnancies (CMHRP) is outcome-focused, with an emphasis on improving birth outcomes through reducing the rate of preterm and low birthweight births and monitors the pregnant Medicaid beneficiary population and prenatal service delivery system using data. CMHRP applies systems and information to improve care and assists members in becoming engaged in a collaborative process designed to manage medical, social and behavioral health conditions more effectively.

Meeting the diverse and complex needs of members requires a holistic, person-centered approach that addresses both physical, social and behavioral health. A holistic approach must consider the social determinants of health (SDOH), which are "conditions in the environment in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks" (Office of Disease Prevention and Health Promotion, 2016). The more complex the needs, the more comprehensive the approach should be for assisting the member with a care plan that addresses the whole person and collaborates with other systems that impact the member's well-being. (Adapted from Case Management Society of America, 2010. *Standards of Practice for Case Management*. Little Rock, Arkansas.)

July 1, 2021 began the start of Medicaid Managed Care in North Carolina. As a result, CMHRP became a collaborative program between several entities, DHB, PHPs, LHDs and DPH. The Division of Health Benefits (DHB) has contracted with five pre-paid health plans (PHP) to manage the Medicaid population and associated components of the population, which includes CMHRP services. The five PHPs are: Healthy Blue of NC-Prepaid Health Plan, AmeriHealth Caritas NC, WellCare of NC and United HealthCare of NC and Carolina Complete Health. These PHPs have subcontracted Care Management for High-Risk Pregnancies (CMHRP) services to the local health departments (LHDs) who are responsible for delivery of services to their community members identified as needing intensive care management for high-risk pregnancies services. DHB, the PHPs and the LHDs, in partnership with the Division of Public Health (DPH), are collaborating to provide these services to improve birth outcomes in the North Carolina Medicaid population and to improve the quality of care while containing costs. For additional information, review the "Management of High-Risk Pregnancies and At-Risk Children in Managed Care- Program Guide" and the individual LHD-PHP executed contracts.

Care Management for High-Risk Pregnancies
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Cherokee Indian Hospital Authority (CIHA)

The Cherokee Indian Hospital Authority (CIHA) has contracted with the North Carolina Department of Health and Human Services (DHHS) to support the Eastern Band of Cherokee Indians (EBCI) in addressing the health needs of American Indian/Alaskan Native Medicaid beneficiaries. This Indian Managed Care Entity is the first of its kind in the nation and will establish a new delivery system called the EBCI Tribal Option. The EBCI Tribal Option is a managed care option for federally recognized tribal members and other individuals eligible to receive Indian Health Service, under 42 CFR 438.14(a).

The EBCI Tribal Option will manage health care for approximately 4,000 Tribal Medicaid beneficiaries residing primarily in Cherokee, Graham, Haywood, Jackson, and Swain counties. The program will have a strong focus on primary care, preventive health, chronic disease management and provide care management for all members and care management service plans for high-need members. The EBCI Tribal Option will coordinate all medical, behavioral health, and pharmacy services in the North Carolina Medicaid and NC Health Choice State Plans, including monitoring the quality of services offered.

Reporting on Performance Metrics:

Pregnant and postpartum members receiving Medicaid will be followed for NC DHHS and PHPs program evaluation and reporting purposes. NC DHHS and PHPs analyze Medicaid claims, birth certificate and care management data for meaningful trends in quality, utilization, care management activity and outcome measures (e.g., adherence to best practice guidelines; achievement of goals for performance measures). Data sources include care management documentation, Medicaid claims, Pregnancy Risk Screening Forms, birth certificate data and other sources.

The Division of Health Benefits has set forth specific Performance and Quality Measures related to CMHRP services. These can be found in the "Management of High-Risk Pregnancies and At-Risk Children in Managed Care-Program Guide" and at the end of the CMHRP Standardized Plan.

Guiding Principles for Care Management:

Care managers:

- Use a member-centered, collaborative partnership approach.
- Whenever possible, facilitate self-determination and self-care through the tenets of advocacy, shared decision-making and education.
- Practice cultural competence, with awareness of and respect for diversity.
- Promote the use of evidence-based care, as available.
- Promote optimal member safety.
- Promote the integration of behavioral change science and principles.
- Link with community resources.

Care managers (continued):

- Assist with navigating the health care system to achieve successful care, for example during transitions.
- Pursue professional excellence and maintain competence in practice.
- Promote quality outcomes and measurement of those outcomes.
- Support and maintain compliance with federal, state, local, organizational and certification rules and regulations.
- Ensure coordination with and avoid duplication of available community services beyond Pregnancy Care Management.
- Identify and assess for social determinants of health (SDoH).

Care Management for High-Risk Pregnancies guiding principles, interventions and strategies are targeted at the achievement of member stability, wellness and autonomy through advocacy, assessment, prioritization, planning, communication, education, resource management, care coordination, collaboration, service facilitation, follow up and evaluation. They are based on the needs and values of the member, and they are accomplished in collaboration with all service providers, including the Pregnancy Management Program. This accomplishes prenatal and postpartum care that is appropriate, effective, member-centered, timely, efficient and equitable.
(Adapted from Case Management Society of America, 2010. *Standards of Practice for Case Management*. Little Rock, Arkansas.)

How is the CMHRP population identified?

Three basic criteria must be met before an individual can be identified as part of the Care Management for High-Risk Pregnancies' population. The individual must: 1.) Currently be pregnant or within 60th day of their postpartum period; 2.) Receive NC Medicaid or be NC Medicaid-eligible (including Presumptive Eligibility period); 3.) Be considered a PHP priority or eligible based on CMHRP programmatic criteria.

There are multiple sources that help identify individuals who may benefit from CMHRP services. These include:

- Use of the DHB maintained, statewide Pregnancy Risk Screening (PRS) Form
  - This is completed by a Pregnancy Management Program provider, then faxed to the member's LHD and PHP
- The PHPs utilize their internal proprietary algorithm to identify their members who need intensive care management services for high-risk pregnancies
  - LHDs are notified of these PHP Priority Members via CareImpact dashboards
- Hospital admission/discharge/transfer (ADT) data feeds
- Direct referrals from providers
- Member self-referral
- Community agency or program referral

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Prior to the shift to managed care, CMHRP utilized the Maternal Infant Impactability Score (MIIS) to determine whether an individual was a priority for CMHRP services. The MIIS was developed by analyzing several years of Pregnancy Care Management (CMHRP legacy program) service delivery data, data from Pregnancy Risk Screening Forms and birth outcome data from vital records. This analysis indicated that members with certain risk factors or combinations of risk factors are "impactable," meaning they may experience a reduced risk of delivering a low-birth-weight infant if they received care management services.

As of July 1, 2021, the MIIS is no longer the priority indicator. Members identified by the PHPs are the **highest of priority**. Care managers will utilize the MIIS to assist them in prioritizing care management activities such as initial outreach and ongoing task organization.

Priority v. Eligible Population within Care Management for High-Risk Pregnancies

Once the population has been identified, members will either be ***priority*** for CMHRP services or members will be ***eligible*** for CMHRP services. A member identified as priority for CMHRP services has been identified by their respective PHP as needing intensive care management services, thus they are considered PHP Priority members and will receive CMHRP services through the duration of their pregnancy and postpartum period. An eligible member is a member who has not been identified as a PHP Priority but may benefit from care management services.

***Priority* Population for CMHRP Services**

Medicaid Managed Care altered the priority population to receive CMHRP services, which is now inclusive of each PHP's internal member risk stratification algorithm. The PHPs will provide the list of PHP Priority Members to the LHDs via CareImpact on a set interval. There may be instances when a PHP would like a LHD to provide CMHRP services to a member, and they fax/call/secure email the referral to the LHD. In these instances, this referral should be treated as a PHP Priority Member. **Members identified as a PHP Priority must receive intensive CMHRP services throughout their pregnancy and postpartum period (through 60th day postpartum) regardless of the member's MIIS.**

Priority members can be identified using two available reports in CareImpact, which includes the Current Pregnancies Patient List (CPPL) and the Current Opportunities (CO) Patient List.

Use of MIIS with Priority Population

The primary purpose of the MIIS within the Priority population is to assist with caseload management:

- If multiple new referrals are received at the same time, then prioritize outreach to those with a higher MIIS
- Arrange daily tasks based upon highest need(s)/MIIS
- In addition to professional judgement and member need, the MIIS can be utilized as a guide to determine an appropriate Engagement Level

Eligible **Population for CMHRP Services**

Time allotment for internal PHP risk stratification and data exchange timeframes will cause a delay in the LHDs receiving the PHP Priority Members' names from the PHPs. As a result of this delay, LHDs should provide CMHRP services to those who are eligible for CMHRP services. In many cases, these eligible members receiving CMHRP services will also display as a PHP Priority when the list becomes available in CareImpact. When this occurs, the member immediately becomes a Priority member and should receive services throughout her pregnancy and postpartum period.

Members are considered eligible for CMHRP services in instances of a direct provider referral, member self-referral, community referrals, CMHRP care manager professional judgement or a Maternal Infant Impactability Score (MIIS) of 200 or greater.

An ***eligible*** member who is not identified as a PHP Priority may benefit from short-term care management services, so their OB Episode may be closed prior to delivery if all member needs have been met. If the decision is made to discontinue providing CMHRP services to a member, then the CM must communicate that decision with the referral source.

What are intensive CMHRP Services?

All PHP Priority members must receive intensive care management services throughout the duration of their pregnancy and postpartum period; however, every member (whether priority or eligible) should receive intensive care management services while they remain in a 'Managed' OB Episode Status.

Intensive care management services are inclusive of:

- Continuous, consistent contact throughout the pregnancy, which requires at least one face-to-face interaction every 30 calendar days; however, some members will require more frequent contact based on their needs
    - Face-to-face interactions are necessary during the pregnancy; however, they are not a requirement of the postpartum period
- Updated Comprehensive Needs Assessment-OB (CNA-OB) at a minimum of every 30 calendar days, or more frequently based on member's needs
- Updated Care Plan at a minimum of every 30 calendar days, or more frequently based on member's needs

Documentation should be completed on the day of the interaction; however, 72 hours allows grace for unforeseen circumstances. Documenting within the 72-hour timeframe should be the exception and not the rule.

Referral Sources

All new referrals need to be triaged to provide services based on members' urgency and need(s). Due to the short-time frame of pregnancy, every effort should be made to engage members in care management as early in pregnancy as possible, which requires timely follow-up on referrals to CMHRP. For CMHRP Priority *and* Eligible members, one completed, or 3 or more attempted Patient-Centered Interactions are expected within 7 business days of the current OB Episode being opened.

If the member's OB Episode was previously closed (regardless of the same pregnancy or a new pregnancy), and a new referral is received, then a new OB Episode should be opened. Follow the CMHRP Step-by-Step Documentation Guide to ensure referrals and subsequent documentation are entered appropriately into VirtualHealth.

Referral sources should be notified of the member's referral status as it relates to CMHRP services.

Pregnancy Risk Screening (PRS) Forms:

All Pregnancy Risk Screening (PRS) Forms, inclusive of follow-up PRS, which are received must be entered into VirtualHealth as quickly as possible and no later than 24 hours of receipt, even if no information has changed since a prior risk screening was entered for the same pregnancy. A CMHRP care manager should be assigned simultaneously.

Hospital Admissions/Discharges/Transfers (ADT)

Hospitalized (inpatient, triage, ED visit) members who are less than 37 weeks gestation need to have a documented attempt to engage as quickly as possible, and no later than within 3 business days of receipt of referral (member identified on OB ADT list or OB Department Queue). There may be other entities who are also contacting the member about the recent hospitalization, including Advanced Medical Home (AMH) Tier 3 care managers or the member's PHP.

- Hospitalized members who are 37 weeks gestation or greater should have their ADT information reviewed to ensure there are no concerns; if concerns are noted, then engage the member appropriately.
- If the CM is ***not*** currently working with the member, but the member appears on the OB ADT report, and they only accessed the hospital for routine testing, then the CM does not need to reach out to the member.
- If the CM ***is*** working with the member, and if it is a visit for NST or ultrasound and no concerns are identified based on the visit, then the CM does not have to reach out to the member within the 3-business day timeframe. The CM should document findings in the Comprehensive Needs Assessment-OB, and then document in a case note that the member appeared on OB ADT list, the medical record was reviewed, and the CM findings may be found in the CNA-OB.

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Regardless of the referral source, each referral should be handled utilizing a similar format.

- All referrals should be documented in VirtualHealth and simultaneously assigned to a CMHRP CM for member information to be assessed.
- Utilize available information to guide the process of prioritizing outreach to priority and eligible members.
- The initial evaluation process should include a review of prior Comprehensive Needs Assessment-OB and/or other care management documentation, information from claims data, the member's medical record and information from the referral source. Any assessment findings should be documented on the Comprehensive Needs Assessment-OB (CNA-OB) and include the source of the information (i.e., Per EMR, member hospitalized for hyperemesis.).
    - A case note describing how the assessment findings were obtained should also be documented (see CMHRP Step-by-Step Documentation Guide).
- Contact Priority and eligible members to engage them in care management, using Motivational Interviewing techniques and document member engagement activities in the Interaction Tracker.
    - As part of the member's care team, offer care management as a support for the member during pregnancy, and coordinate with their maternity care provider to address needs and goals to ensure the member receives the best possible care during pregnancy and in the postpartum period
    - Care management is one of the value-added services offered by the member's insurance, Medicaid.
    - If the member verbalizes that they do not want to engage with the CM and/or refuses referrals for linkage, complete the Interaction Tracker documenting the member outreach, check, "Member opts out of Case Management," and review the "CMHRP Step-by-Step Documentation Guide" to complete the appropriate process for OB Episode closure.
- Once the member is in an open OB Episode, continue to document information gathered through ongoing assessment on the CNA-OB and document the care management activities in the Interaction Tracker.
    - Each time the assessment is updated there should be a corresponding interaction documented, which reflects how the information was obtained (e.g., telephone call, home visit, etc.)
- A Comprehensive Needs Assessment-OB (CNA-OB) must be initiated for all members who are receiving intensive care management services. This includes members who do not have a Pregnancy Risk Screening Form available, or one is not provided. The CNA-OB should be continuously updated with all new assessment findings as they are learned, and at least every 30 calendar days and during the postpartum period, for all members.
    - The CNA-OB is a working document that shows the member's past and current medical, behavioral and social history, as well as current needs. Any care team member should be able to review a CNA-OB and feel secure that they are aware of all pertinent medical and psychosocial information that will assist them in working with the member.

- The Comprehensive Needs Assessment-OB (CNA-OB) will auto-generate *some* **care plan** needs based on the member's assessment.
    - It is recommended to utilize the auto-generated care plans; however, additional identified needs may be manually entered onto the Care Plan.
    - Perform regular **goal reviews** with the member and document progress toward the goal, or lack thereof, at a minimum of every 30 days, for members with "High," "Medium" and "Low" Engagement Levels. Members assigned an "Intermittent" Engagement Level should have goals reviewed at a minimum of every 90 days.

Providing CMHRP in the Postpartum Period

There will be situations when an individual has not received CMHRP services during their pregnancy, but a referral was warranted in their postpartum period. This postpartum period (date of delivery through the 60th day after delivery), is inclusive of all postpartum periods whether the pregnancy concluded with a live birth, abortion, fetal demise or stillbirth. Should a LHD receive a referral for the member in the postpartum period, then current care management needs should be assessed, and services should be provided accordingly.

What is expected of the CMHRP Care Manager?

It is expected that CMs will use professional judgement, in collaboration with programmatic guidelines, to provide quality, comprehensive care management services to identified members. Care managers are also expected to review and utilize the CMHRP Toolkit to ensure best practice service delivery.

Care managers provide a variety of services in the form of population management and direct care management, as integral members of the maternity care team. Once identified and actively receiving CMHRP services, members must have clear documentation of a Comprehensive Needs Assessment-OB, interactions, care plan and goal(s) and other Care Management for High-Risk Pregnancies activities. Specifically, CMHRP activities done with or on behalf of members are recorded as interactions, including outreach to members to engage them in care management.

Care Management for High-Risk Pregnancies Core Functions:
(Adapted from Case Management Society of America, 2010. *Standards of Practice for Case Management*. Little Rock, Arkansas.)

- Conduct initial and ongoing **assessment** of member's comprehensive medical and psychosocial needs.
- Facilitate **communication and coordination** between the member's care team, and involve the member in the decision-making process, to coordinate needed care and services.
    - This process is best achieved by the CM being embedded or integrated as part of the maternity care team including being present in the office on a minimum of weekly basis and by attending practice care conference meetings, as appropriate.
- **Educate** the member and members of the maternity care team about options, community resources and psychosocial concerns related to the member's clinical and social needs, so that timely and informed decisions can be made.

Care Management for High-Risk Pregnancies Core Functions (Continued):

- Provide referrals to community resources, as needed, and ensure that appropriate follow up with each referral takes place. This may involve acting as a liaison between the member and a community agency in the initial stages of referral, and additional follow up with the member and the community agency to ensure the member is effectively linked into care.
- When completing an initial referral on behalf of the member, document this information in the Interaction Tracker.
- Based on the member's needs, referral status and follow up would be documented in the Care Plan.
- **Empower** the member to participate in the decision-making process related to their health care.
- **Encourage** the appropriate use of health care services and strive to improve the quality of care and maintain cost effectiveness on a case-by-case basis.
- The care management functions of assessing, identifying needs, establishing goals and documenting interactions are essential to **developing a care plan** with the member. These functions also ensure the member, family, maternity care provider, other health care providers and/or service providers are united to meet the member's identified needs.
- Document attempted and completed interactions that reflect activity to respond to the identified needs and achieve the member's goals within the Interaction Tracker. Care Plans should be updated to indicate member's progress towards the goal within the goals tab.
- **Assist** the member in any care transitions. Strive to **promote** member self-advocacy and self-determination. **Advocate** for both the member and the payer to facilitate positive outcomes for the member, the health care team and the payer. The primary focus of care management is always addressing member needs and goals.

Coordination of Care:

A core expectation of the CM is to ensure that the member's health care and other services are well coordinated. The CM should identify all other providers currently or recently involved in the care of the member. These include maternity care provider(s), primary care provider(s), other medical or behavioral health care providers, substance use disorder treatment, social service providers, including Child Protective Services, other CMHRP care managers, Care Management for At-Risk Children Care Managers, and other community programs. Many of these providers can be added to the member's care team within VirtualHealth (Care Team→Select "Other"→Select Parent, Caregiver, Partner, etc.).

The CM should review what services the member is receiving from each of these providers at the time of initial assessment. It is the responsibility of the CM to establish communication with any other services that are already connected to the member. This should be done as part of the process of developing a care plan that reflects alignment of the care and services the member is receiving and avoids duplication of services.

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Collaboration with Maternity Care Provider (Pregnancy Management Program, PMP):

Care Management for High-Risk Pregnancies services must be delivered in close collaboration with the member's maternity care provider. Care managers must communicate regularly with the maternity care provider about the member's progress towards goals, as well as current needs and issues that may impact clinical care. Care managers are a part of the member's care team and must develop effective practice-specific communication strategies to ensure coordination of care.

All Pregnancy Management Program (PMP) practices, including those with low volume, should have regular, consistent care management presence. The degree of embedding in a PMP practice will vary by location based on member volume and impactability.

- PMPs with high member volumes and with higher proportions of priority members may require multiple embedded CMs.
- Regional high-risk centers that serve members from multiple counties may need regular presence of CMHRP CMs from additional counties.
    - For members who receive prenatal care in another county, one CM in the home county should work with members who go to the same "out-of-county" practices.
    - This collaboration fosters better relationships between the CM and out-of-county PMP and in turn benefits the member as the CM is familiar with their PMP's operations/practices.

Collaboration with other medical providers:

The care manager should ensure the maternity care team is aware of all medical services the member is receiving at the time of entry to prenatal care. This can be determined through member assessment, review of the medical record and review of available claims data. The care manager can inform the maternity care team of any medical services the member has received of which they may not already be aware.

If the member is referred during pregnancy for medical services outside of the maternity care setting, the CM should help coordinate this care, including ensuring needed appointments are scheduled, that the member is able to attend the appointments and that updates to the medical care plan are shared across the care team. For example, if the member is referred to a specialist, such as a psychiatrist or cardiologist, who orders specific tests or prescribes a new medication, the CM should ensure that the member understands and is able to adhere to these recommendations and that the maternity care team is aware of any changes.

Care Management for High-Risk Pregnancies
Standardized Plan

Collaboration with community programs:

Care managers should maintain current knowledge of the programs serving pregnant individuals in their communities, including referral procedures and policies related to release of information. This knowledge is inclusive of value-added services provided by each PHP. Care managers should proactively obtain consent from a member to discuss the member's care plan with other agencies serving the member, preferably by having the appropriate consent form on hand at the time of the member assessment. This includes programs offering substance use disorder treatment and other behavioral health services.

Collaboration between CMHRP and PHP Care Management Services

The PHPs receive a list of members who are receiving CMHRP services from the LHDs. This list is automatically sent to the PHPs on a set interval. PHPs will utilize this list to ensure duplicative services are not provided to the same members.

After serving a member through the pregnancy and postpartum period, the member may have ongoing needs, which would warrant continued care management services through the member's PHP. In these situations, the member should be referred to the applicable PHP for continued services. It is important that services are coordinated and organized to best meet the needs of the member; therefore, a warm "handoff" from the CMHRP CM to the PHP is expected.

Collaboration with home visiting or other care coordination programs for pregnant women:

Members who do not meet priority criteria for Care Management for High-Risk Pregnancies should be connected to other programs in the community that serve individuals who are pregnant, as appropriate, based on eligibility criteria for those programs. Most PHPs offer care management services for their low-risk pregnant members. If a LHD closes a PHP Priority member's OB Episode, then the PHP is entitled to engage that member into their internal pregnancy care management program. It is in the CMHRP CM and member's best interest for intensive services to be provided in the community at the local level by the CMHRP CM.

Eligible members whose needs have been met and the OB Episode has been 'graduated' can be referred to other home visitation and/or case management services (e.g., Nurse Family Partnership, Adolescent Parenting Program, Healthy Beginnings, Healthy Families, Baby Love Plus, Parents as Teachers, etc.). PHP Priority members must continue to receive CMHRP services during their pregnancy and postpartum period.

Collaboration with other CMHRP Care Managers (Member Sharing):

In situations where members are receiving prenatal care in an out-of-county Pregnancy Management Program, it may be efficient and effective for the home-county CMHRP CM to work collaboratively with the CM embedded at the member's PMP. This arrangement should begin with a conversation between the two CMs. It should be noted this arrangement will only work at the discretion of the embedded CM and their availability. The embedded CM may have an established relationship with the PMP provider, access to the member's medical record and the maternity care team. The embedded CM can also work with the member during scheduled medical appointments, as available. The home-county CM is typically the assigned CMHRP CM, but the assignment can be adjusted based on whatever the two CMs agree is the most effective arrangement for the member.

Any CM working with the member must document all activity in the member's record. This includes documenting interactions, updating care plans and goals and the CNA-OB. When more than one CMHRP CMs is involved, the two CMs should ensure regular communication, especially after each interaction with the member.

While engaging a member at their medical appointment is ideal, there will be times when the out-of-county CM is not available to meet with a member. The home-county CM should consistently be seeking other modes of communication with the member such as home visits or community encounters (library, WIC office, LHD office, DSS office, etc.).

Transfer between CMHRP Care Managers:

*** If a new address is not known, then the member CANNOT be transferred**
When a member moves to another county during pregnancy or the postpartum period:

- Call the lead CMHRP CM in the member's new county of residence. An updated list is available in the CMHRP Toolkit and in VirtualHealth (KnowledgeBase)
- *After* talking with the lead CM, change the Primary Care Manager and Pregnancy Care Manager to the new CM's name;
- Change the member's address to reflect the new county;
- Set yourself a pending task for 7 calendar days to ensure member has had appropriate outreach by the new CM;
- The new CM is responsible for adjusting tasks, updating the CNA-OB and care plans, Episode Status, Engagement Status, Serving Entity, etc.;
- The transition from one CM to another should reflect a coordinated, "warm" hand-off and should not result in interruption of care management services.

Care Management for High-Risk Pregnancies
Standardized Plan

OB Engagement Level:

Within VirtualHealth, High, Medium and Low Engagement Levels all correspond to intensive care management, meaning there is at least one intervention *with* the member every 30 days.

All members who are receiving CMHRP services should have an Engagement Level of High, Medium or Low, unless the OB episode is in "Monitored" status, and the Engagement Level should be set to "Intermittent." Intermittent *may* be used for members who are in county jail (not prison), and members who are involuntarily committed for behavioral health needs.

It is the CMHRP CM's responsibility to determine the appropriate follow up/monitoring frequency based on each member's need(s) and assign the corresponding Engagement Level based on planned care management activity. The Engagement Level will change over time, as member needs change. The Engagement Level should reflect the current level of need for care management follow up, either with or on behalf of the member. The Engagement Level should align with member need(s), which correlate with the expected number of Patient Centered Interactions (PCI) within a given timeframe (i.e., 30 days).

The definitions for each Engagement Level are as follows:

Engagement Level	Frequency of Contact with Member
High	**Daily to weekly PCI with the member (4 or more x / 30 days)**
Medium	**Bi-weekly PCI with the member (2-3 x / 30 days)**
Low	**Monthly PCI with member (1 x / 30 days)**
Intermittent	**Monthly to quarterly (90 days) PCI with member (Less than 3x /90 days)**

Care Management for High-Risk Pregnancies
Standardized Plan

OB Episode Status

Episode Status	Definition
Pending	Referral received and has not yet been assigned to a primary care manager and either no contact attempts have been made or no successful contact resulting in either enrollment or refusal of CM has yet to be made.
Referred	Assigned to a primary CM and either no contact attempts have been made or no successful contact resulting in either enrollment or refusal of CM has yet to be made.
Engaged	Member accepted care management (as documented in Interaction Tracker).
Managed	Member has agreed to care management; necessary assessments are completed; the member has signed off on their care plan which encompasses at least one need with a problem status as "managed" and a corresponding goal.
Monitored	Member has an open care plan, but *intensive*, comprehensive care management is not possible due to current member circumstances. Care manager (CM) is simply monitoring the member in a more passive way because member has been admitted to an inpatient facility and therefore, CM is unable to provide services at this time. CM will monitor and resume care after member is discharged. All problems on CarePlan are set to Monitored and/or Monitored/Declined.
Graduated	At least one problem is set to "Graduated." The rest of the Care Plan problems can be set to "Graduated" or "Declined" for a selected episode that was previously in a state of "Managed" or "Monitored."
Declined	Member declined care management services upon initial outreach (as documented in the Interaction Tracker) or member declined continuation of services at any point after an episode was set to "Engaged, Managed or Monitored." Within the Care Plan, "Declined" also indicates that although the need is identified, it is either not a concern by the member or applicable during the current episode.
Unable to Reach (UTR)	Member could not be reached ***prior*** to accepting/declining care management. **CMs should follow CMHRP program guidance for required outreach attempts before utilization of this closure reason.*
Lost Contact	Member could not be reached ***after*** enrollment into care management.
Terminated	Member lost Medicaid and is no longer eligible for care management services. This includes members that move their residence out of North Carolina. **As of July 1, CMHRP program may use "Terminated" as an OB Episode closure reason.*
Deceased	Member deceased, requiring episode to be closed.
Ineligible	Member had an episode created in error and/or does not meet program qualifications

OB Episode Closure

Prior to closing an OB Episode for "Unable to Reach," the CM:

1. Must attempt 5 different ways on 3 different days of outreach.
    a. A letter is not considered one of those attempts.
2. Outreach to the member's Pregnancy Management Program (to determine member's upcoming appointment) must also be completed. If the member has an upcoming appointment, then the CM should see the member at that scheduled appointment.
3. Prior to closing an OB Episode for a priority member, the case must be reviewed with the care management supervisor.

It is imperative members who are identified as a PHP Priority receive intensive CMHRP services from the LHD through their pregnancy and postpartum period. Early closure of the OB Episode should be avoided, when possible.

When a member who has been receiving Care Management for High-Risk Pregnancies services are closed:

- Inform the member and the care team that the member will no longer be receiving CMHRP services, as appropriate.
- For members who receive both CMHRP and other care management services during the pregnancy, ensure the other care managers have been notified of the CMHRP closure.

Care Management for High-Risk Pregnancies
Standardized Plan

CMHRP Common Pathway

Prenatal Period:

Prenatal Care Access

1. Ensure that the member is established with a maternity care provider.
2. Assess and address any barriers to keeping prenatal visits.
3. Assist with the application process for Medicaid, including facilitating Presumptive Eligibility (PE) determination, if needed.
4. Establish with the member that you are a resource for helping to enable them to attend all prenatal appointments and consultations, complete all labs, ultrasounds and any other procedures that are included in clinical care plan.
5. Ensure that the member can obtain all prescribed medications and understands how to take them. (NOTE: Individuals who are pregnant and who receive Medicaid have a $0 copay for prescription medications).

Referrals and Education

★ CMHRP CMs should refer to the *CMHRP Pathway: Patient Education* for guidance on the timing of member education and the use of approved materials.

6. Refer for WIC, if not already completed.
7. Educate member that prenatal visits are a priority for the monitoring of their health status and that of their baby.
8. Educate the member about the importance of avoiding, discontinuing or reducing tobacco and alcohol use and substance misuse, including the value of medication-assisted therapy for opioid use disorder, eating a healthy diet including proper hydration, taking a prenatal vitamin and getting regular prenatal checks.
9. Discuss the member's (and her partner's) reproductive life plan and review family planning options. Ensure the maternity care provider is aware of the member's desired method of contraception for the postpartum period.
10. Provide educational materials and/or referrals as appropriate based on member need.
11. During your encounters with the member, encourage them to verbalize any concerns or issues that they are having. Address those that are within your scope of practice and seek assistance for those that are not.

Collaboration with Maternity Care Provider

12. Communicate with the maternity care provider to ensure member understanding of the clinical care plan to provide needed support for the plan.
13. Share relevant information learned through the care management assessment process with the maternity care provider and assist the provider with incorporating care management findings into the clinical care plan, as appropriate.
14. Notify the maternity care provider if the member is being followed by any other specialists, including mental health professionals, or is receiving prescriptions from other providers.
15. Keep the lines of communication open between the member, the provider and yourself. If at any time you have concerns, contact the member's maternity care provider. This type of teamwork is essential for a successful outcome.

Monitoring and Follow-Up

16. Ensure member has kept all medical appointments (maternity care and other specialists).
17. Ensure member has kept all scheduled ultrasound appointments.
18. Evaluate the status and "close the loop" of any referral made for the member. Follow up as appropriate to ensure referrals are completed.
19. Review the signs and symptoms of preterm labor with the member each time you speak at each interaction. Make sure the member understands what steps to take if experiencing any of these symptoms. Check with the member's provider to determine what protocol they follow. Typical standard warning symptoms of preterm labor are as follows:
    - Six or more contractions in an hour
    - Cramping in the abdomen that comes and goes and may or may not be associated with diarrhea
    - Any change in vaginal discharge
    - Pressure that feels like the baby is "pushing down"
    - Low, dull backache that comes and goes, or does not go away
20. Assess for any new problems, concerns or needs.

Postpartum period:

Postpartum Care Access

1. Discuss the importance of scheduling and attending the postpartum clinical visit and ensure that the member is seen for a postpartum visit with the provider.
2. Assist with transportation referrals for postpartum clinic visit, if indicated.
3. Review family planning options and assist the member in obtaining the contraceptive method of their choice.

Referrals and Education

★ CMHRP CMs should refer to the *CMHRP Pathway: Patient Education* for guidance on the timing of member education and the use of approved materials.

4. Discuss the importance of newborn care, including well childcare and immunization schedules, and ensure the member is connected to a well childcare provider.
5. Refer the member to the local Department of Social Services for Medicaid eligibility determination, and assist member in applying for ongoing Medicaid coverage, including Be Smart (family planning coverage), if applicable.
6. Refer the member to WIC.
7. Assess for any new needs in the postpartum period and assist as necessary with referrals, education, and support.
8. Assess newborn for referrals into any needed services, such as Care Management for At-Risk Children (CMARC) or Early Intervention.

Collaboration with Maternity/Postpartum Care Provider

9. Ensure that the maternity care provider is aware of any issues that arise during the postpartum period.
10. Assist with referrals for any needed ongoing primary care after the postpartum period, including the transition to a primary care medical home, if applicable.

CMHRP Performance and Quality Measures

Performance Measures

Performance Measure	Measure Description
Monthly & Rolling Penetration Rate	Numerator= any member with a completed care management encounter **(Patient Centered Interaction)** in the past 30 days. Denominator= Number of women ages 14-44 years.
Outreach Rate {CMHRP)	Numerator= Number of members with a "Completed" encounter **(Patient Centered Interaction)** "with member" OR 3 or more "Attempted" encounters "with Member" within 7 business days of the current OB Episode being opened. Denominator= Number of members referred for CMHRP services in the reported month.
"Active Care Management" **Care Management Rate (CMHRP)**	Numerator= Number of members engaged in care management who have a signed Care Plan within 15 calendar days of engagement in CMHRP services (This means the member is in "Managed" Episode Status; the care plan was signed by member within 15 calendar days of opting into CMHRP services) Denominator= Number of members with an open OB Episode in the reported month.

Quality Measures

Quality Measures	Measure Description
Low Birth Weight Births	**N** = Number of live, singleton births weighing <2,500 grams at birth in the CMHRP enrolled population during the measurement period. D = All live, singleton births in the CMHRP program-enrolled population during the measurement period.
Timeliness of Prenatal Care (PPC)	**N** = Number of members who received a prenatal care visit in the first trimester. D = All members who received CMHRP services who had a completed CMHRP CM contact during the measurement period.
Postpartum Care (PPC)	N = Number of members who received a postpartum care visit between 7 and 84 days after delivery. D = All members who received CMHRP services who had a completed CMHRP CM contact during the measurement period.

CMHRP Time Frames

PMP send PRS form to LHD & PHP	Within 7 Business Days of PRS form Completion.
LHD receives PRS form from **PMP**	LHD ENTER PRS into VH Within **24 hours** of receiving PRS. CM should be assigned at this time.
Initial Outreach to member by LHD *Performance Measure: *Outreach*	***Members with a completed encounter with member or 3 or more attempted encounters with member within 7 business days of the current 08 Episode being opened:*** **Initial** attempt to reach ELIGIBLE member made within **3 business days** of receipt of referral 3 or more attempts to reach member and/or a completed encounter (PCI) must be made within **7 business days** of receipt of referral.
Member Sign Care Plan *Performance Measure: *Active Care Management*	***Members engaged in Care Management will have a signed Care Plan within 15 days of-engagement in CMHRP services:*** *Care Plan signed by member within **15 days** of member opting into CMHRP services* *(which is the date the OB Episode Status was captured as "Engaged").*
Ongoing Outreach to member by LHD * Feeds into the Utilization/Penetration Rate	Patient Centered Interactions (PCI) should be completed **at *a minimum*** of **every 30 calendar days**; more frequently based on the member's engagement level which is based on member needs.
Care Plan Update	Updated at a ***minimum*** of **every 30 days** and as new information is obtained.
CNA-OB Update	Updated at a ***minimum*** of **every 30 days** and as new information is obtained.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: POSTPARTUM HOME VISIT ASSESSMENT PROGRAM

DATE DEVELOPED: 9/96
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/18; 6/20; 6/22; 6/23; 6/24

I. POLICY:

The Division of Public Health Services Nurse will provide home visits to postpartum women regardless of insurance status who reside in Rockingham County, including those postpartum women who deliver outside of the county. **The PHN may also offer home visits to postpartum women who reside in neighboring counties who would not otherwise have access to a home visit.**

II. PURPOSE:

Postpartum visits provide health, social support, and educational services directly to families. Postpartum visits promote and provide timely referral of problems and improve health of new mothers. Services will be provided as detailed in the most current Division of Medical Assistance Policy for Postnatal Assessment and follow-up care.

III. GUIDELINES:

A. Population served:

Postpartum women who reside in Rockingham County **and neighboring counties** are eligible for services.

B. Referrals

1. UNC Health Rockingham – The postpartum/newborn (PP/NB) nurse from the Division of Public Health Services visits the hospital to obtain referrals, meet clients, and schedule appointments for visits.

2. Deliveries at Other Facilities - Birth certificates may be utilized to obtain referral information for clients who deliver at other facilities including but not limited to **Cone Health Women's and Children's Center (WCC)** in Greensboro, NC. A letter is sent with the appointment date/time and a contact name with a number is provided. The nurse may make an unannounced home visit in order to offer/schedule a postpartum/ newborn assessment visit if still within the timeframe of 45 days or less.

3. The PP/NB nurse may receive referrals from area OBGYN offices on women who are nearing their delivery date or who have recently delivered. **The PP/NB nurse may also receive referrals from**

area pediatricians' offices on newborns who need a health check.

4. Telephone referrals – telephone referrals may be made by any health care provider, concerned individual, including self-referral.

5. Care Management for High Risk Pregnancies (CMHRP) and Care Management for At Risk Children (CMARC) staff may notify the postpartum nurse of pending or recent deliveries.

6. The PP/NB nurse may visit clients who are at a WIC appointment to offer services in-person.

C. Coordination of Visits

For CMHRP participants, the postnatal nurse assigned to make postpartum visits is responsible to collaborate with the care manager assigned to client.

The nurse should collaborate with the care manager before and after the visit to discuss plan of care/goals.

D. Timeliness of Visits

A home visit is attempted within **2-3 weeks** of hospital discharge, if possible. **Nurse may visit up to 60 days after delivery.**

E. Referrals and Follow-Up

1. Copy of the completed Postpartum Assessment is sent to the appropriate physician.

2. Nurses are to notify the physician regarding abnormal findings and follow up based on orders and/or client needs using nursing judgment.

3. Referrals to Social Worker, CMARC Program, Nutrition counseling, community agencies and services based on individual need of the client. Education on sickle cell trait and disease, free testing, and on-site counseling for individuals with sickle cell syndrome will be referred to the Sickle Cell Disease of the Piedmont for adults; children under 18 will be referred to the sickle cell nurse at the Division of Public Health Services. Coordination of services will be made through interagency referrals through various programs offered through the Division of Public Health Services.

4. Follow up with client as needed. A note/business card will be left at the home for the client to call and reschedule an appointment when a visit is made and client is not at home.

F. Records

Policies for management of medical records are found as part of Division of Public Health Services' Medical Record Policy.

Confidentiality of client information will be followed according to agency policy and the Division of Public Health Services HIPAA Compliance Policy.

1. Composition and Organization

Postpartum

a. Physician orders
b. Postpartum Home Visit Assessment Record/Nurses Note
c. Edinburgh Postnatal Depression Scale
d. Release of Information/Consent for Treatment
e. HIPAA Forms
f. Referrals

2. Documentation

a. Must be in compliance with Department Policy. The most recent state postpartum form is used for documentation of the visit and serves as the template for the EHR note.
b. Edinburgh Postpartum Depression Scale
c. Consent for Treatment/Release of Information must be signed by the postpartum client for self and infant. A copy is placed in infant's chart.
d. A HIPAA Notice of Privacy Practices and Authorization for Use and Disclosure of Client Health Information must be signed for the postpartum/newborn visit and a copy is placed in infant's chart.
e. Documentation occurs both electronically and in hard copy.

G. Quality Assurance

1. An audit of the Postpartum Program will be completed quarterly with a minimum of 6 clinical records reviewed.

2. Findings from the quarterly clinic record audit will be summarized and staff will be given a copy of the report.

3. Procedures will be taken to make improvements as a result of any deficiencies found during the clinical record review.

a. A corrective plan will be implemented to correct deficiencies found during the clinical record audit.
b. A timetable will be made for making the necessary improvements.

c. Program plans and procedures will be reviewed annually and as needed for revisions and updates.

d. An electronic Satisfaction Questionnaire regarding the newborn/ postpartum visit will be sent to the mother via text message for all newborn/postpartum visits. The forms will be reviewed and the results documented. All staff will be notified of the findings. This information will be used to provide improvement measures for the Newborn/ Postpartum Program.

H. Billing Guidelines

1. A home visit is reimbursed once per pregnancy and billed per date of service.

2. Diagnosis code must support medical necessity (Z39.2) and CPT 99501.

3. Reimbursement rate is per DMA guidance.

I. Civil Rights

1. Postpartum visits are provided solely on a voluntary basis and individuals are not coerced to receive a particular service.

2. Acceptance of postpartum visit is not a prerequisite to eligibility for or receipt of any other program/service involvement or benefits.

3. No person on the grounds of age, sex, race, color, creed, religion, political affiliation, national origin, or physical handicap will be denied benefits or services.

4. The Postpartum/Newborn nurse will maintain client confidentiality following the Division of Public Health Services Confidentiality Policy and the Division of Public Health Services HIPAA Compliance Policy.

J. Staff Qualifications

1. This service must be provided by a RN licensed in the state of North Carolina who is trained in postpartum/newborn assessments.

2. The agency will ensure training of all postpartum home visiting staff and implementation of evidence based health literacy strategies in newborn assessment home visits to assure parents and clients can read, understand, and apply health information to make health decisions to improve health outcomes.

3. The agency will increase staff awareness of disparities in health status and service delivery, especially disparities related to race/ethnicity, disability, and socioeconomic status. This will be accomplished through annual staff training, workshops, during orientation, and annually with review of policies.

4. The agency will promote customer friendly services that meet the needs of populations that are underserved.

IV. HOURS OF OPERATION:

Normal hours of operation are Monday – Friday, 8 a.m. until 5 p.m.; exceptions are county holidays and adverse weather when the Division of Public Health Services may be closed or delayed. Some visits may extend beyond 5 p.m. with the supervisor's approval.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NEWBORN HOME VISIT ASSESSMENT PROGRAM

DATE DEVELOPED: 9/96
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/18; 6/19; 6/20; 6/22; 6/23; 6/24

I. POLICY:

The Division of Public Health Services nurse will provide home visits to newborns living in Rockingham County, including those children born outside the county. **The PHN may also offer home visits to parents of newborns who reside in neighboring counties who would not otherwise have access to a home visit.**

II. PURPOSE:

Newborn home visit assessments deliver health, social support, and educational services directly to families in their home. It is a means for follow-up on the infant's health; to counsel on infant care; to follow-up on newborn screening; and to arrange for additional appointments for the infant or referral to CMARC. Current services will be provided as detailed in the most current Division of Medical Assistance Home Visit for Newborn Care and Assessment.

III. GUIDELINES:

A. Population served: Infants age birth to 60 days who reside in Rockingham County **and neighboring counties** are eligible for this service.

B. Referrals

1. UNC Health Rockingham – The postpartum/newborn (PP/NB) nurse from the Division of Public Health Services visits the hospital to obtain referrals, meet clients, and schedule appointments for visits.

2. Deliveries at Other Facilities - Birth certificates may be utilized to obtain referral information for clients who deliver at other facilities including but not limited to **Cone Health Women's and Children's Center (WCC)** of Greensboro, NC. A letter is sent with the appointment date/time and a contact name with a number is provided. The nurse may make an unannounced home visit in order to offer/schedule a postpartum/ newborn assessment visit if still within the timeframe of 45 days or less.

3. The PP/NB nurse may receive referrals from area OBGYN offices on women who are nearing their delivery date or who have recently delivered. **The PP/NB nurse may also receive referrals from**

area pediatricians' offices on newborns who need a health check.

4. Telephone referrals

   a. Hospitals or physicians may phone program coordinator or PP/NB nurse to request a visit be made as priority.
   b. Hospitals from out of county or other health departments may make referrals.
   c. Pediatric offices may phone program coordinator or PP/NB nurse to request a visit.

5. Care Management for High Risk Pregnancies (CMHRP) and Care Management for At Risk Children (CMARC) staff may notify postnatal nurse of pending or recent deliveries.

C. Coordination of Visits

For CMHRP participants, the postnatal nurse should collaborate with the CMHRP/CMARC care manager before and after the visit to discuss plan of care/goals to inform/ discuss with care manager of assessment/findings.

D. Timeliness of Visits

A home visit is attempted within **2-3 weeks** of hospital discharge, if possible. Nurse may visit up to **60 days after delivery**.

E. Referrals and Follow-Up

1. Copy of the completed Newborn Assessment is sent to the appropriate physician.

2. Nurses are to notify the physician regarding abnormal findings and follow up based on orders and/or client needs using nursing judgment.

3. Referrals to Social Worker, CMARC Program, community agencies and services based on individual need of the client.

4. Follow up with client as needed. Documentation will be made in the client's medical record for follow up of referrals.

5. Coordinates health care of child and his/her family with other professionals and agencies. Provides collaboration with other health department programs to incorporate services to meet the client's total needs.

6. A note/business card will be left at the home for the client to call and reschedule an appointment when a visit is made and client is not home.

F. Records

Policies for management of medical records are found as part of the Division of Public Health Services Medical Record Policy.

Confidentiality of client information will be followed according to agency policy. The RN will determine what information can be released and what information must be redacted without another individual's consent for its release.

1. Composition and Organization

Newborn
(1) Newborn Home Visit Assessment Record
(2) Nurses Notes
(3) Release of Information/Consent for Treatment
(4) HIPAA Forms

2. Documentation

a. Must be in compliance with Department Policy. The most recent state approved Newborn Home Visit form is used for documentation of the visit. The Newborn Home Visit form is documented in the electronic health record (EHR) and must include:

- Family demographics
- Assessment of the home environment
- Prenatal history
- Assessment of newborn nutrition
- Assessment of newborn basic care and care giver skills
- Newborn physical assessment
- Targeted anticipatory guidance and education based on history and assessment and parental concerns
- Coordination with other care providers
- Referral for identified concerns or problems
- Linkage to local resources as needed

b. Consent for Treatment/Release of Information must be signed for the newborn and placed in chart.

c. A HIPAA Notice of Privacy Practices and Authorization for Use and Disclosure of Client Health Information must be signed and placed in chart.

G. Quality Assurance

1. An assessment of the Newborn Program will be completed quarterly with a minimum of 6 clinical records reviewed.

2. Findings from the quarterly clinic record audit will be summarized and staff will be given a copy of the report.

3. Procedures will be taken to make improvements as a result of any deficiencies found during the clinical record review.

   a. A corrective plan will be implemented to correct deficiencies found during the clinical record audit.
   b. A timetable will be made for making the necessary improvements.
   c. Program plans and procedures will be reviewed annually and as needed for revisions and updates.
   d. An electronic Satisfaction Questionnaire regarding the newborn/ postpartum visit will be sent to the mother via text message for all newborn/postpartum visits. The forms will be reviewed and the results documented. All staff will be notified of the findings. This information will be used to provide improvement measures for the Newborn/Postpartum Program.

H. Billing Guidelines

1. A home visit for Newborn Care and Assessment is reimbursed once per lifetime. An infant cannot receive both a newborn home visit and an EPSDT visit on the same date.

2. A home visit for Newborn Care and Assessment cannot be reimbursed when provided on the same date as Maternal Care Skilled Home Visit.

3. Diagnosis code must support medical necessity (ICD 10 codes as appropriate – Z00.110, Z00.111, Z00.121, or Z00.129) and CPT code 99502.

4. Reimbursement rate is per DMA guidance.

I. Civil Rights

1. Newborn visits are provided solely on a voluntary basis and individuals are not coerced to receive a particular service.

2. Acceptance of newborn visit is not a pre requisite to eligibility for or receipt of any other program/service involvement or benefits.

3. No person on the grounds of race, color, age, religion, creed, sex, national origin, political affiliation, or physical handicap will be denied benefits or services.

4. The Postpartum/Newborn nurse will maintain client confidentiality following the Division of Public Health Services HIPAA Policies.

J. Staff Qualifications

1. This service must be provided by a RN licensed in the state of North Carolina who is trained in postpartum/newborn assessments.

2. The agency will ensure training of all newborn assessment home visiting staff and implementation of evidence based health literacy strategies in newborn assessment home visits to assure parents and clients can read, understand, and apply health information to make health decisions to improve health outcomes.

3. The agency will increase staff awareness of disparities in health status and service delivery, especially disparities related to race/ethnicity, disability, and socioeconomic status. This will be accomplished through annual staff training, workshops, during orientation, and annually with review of policies.

4. The agency will promote customer friendly services that meet the needs of populations that are underserved.

IV. HOURS OF OPERATION:

Normal hours of operation are Monday – Friday, 8 a.m. until 5 p.m.; exceptions are county holidays and adverse weather when the Division of Public Health Services may be closed or delayed. Some visits may extend beyond 5 p.m. with the supervisor's approval.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: POSTPARTUM ASSESSMENT HOME VISIT PROTOCOL

DATE DEVELOPED: 8/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/18; 6/19; 6/20; 6/22; 6/24

I. POLICY:

The Division of Public Health Services Nurse will provide home visits to postpartum women who reside in Rockingham County **and neighboring counties** and will adhere to the North Carolina guidelines for the postpartum home visit protocol.

II. PURPOSE:

Postpartum visits provide health, social support, and educational services directly to postnatal women. Postpartum visits promote and provide timely referral of problems and improve health of new mothers. The purpose of this policy/protocol is to establish normal findings for the post-partum visit. Any abnormal findings identified will be documented in the electronic health record (EHR) and followed up or referred as indicated.

III. GUIDELINES:

A. Assessment -

Normal findings will be documented as such in the electronic health record with no additional documentation required unless otherwise indicated. Any finding that is considered as abnormal will be noted in the electronic health record with deviations from normal expectations supported by appropriate documentation. Present/Not present will be documented in the EHR. Anything noted that is considered abnormal will be supported with the appropriate documentation in the EHR. Areas requiring descriptive documentation will be completed based on the assessment of the nurse (including areas that can be answered neither "Normal/Abnormal" or "Present/Not present"). Some areas need descriptive information to document appropriately. Expected findings are noted below:

1. Data Entry

   a. Enter all data as required for general patient encounter per latest assessment forms.
   b. Enter Newborn initial assessment information as required by system. Include Medicaid number**,** if available, and Newborn Medical record number (complete all areas).

c. Complete mother's information**,** including Medicaid number if available, as required in the system (complete all areas).

2. Prenatal History (Yes/No)

a. Source of Patient Care (either through patient record or patient report) - patient had no complications and received prenatal care (document). Please note where mother received her care and the hospital where delivery occurred (do not use hospital abbreviations).
b. Alcohol use - if yes, please note type, how often, amount consumed, and if referral is indicated.
c. Illicit Substances - if yes, please note type, how often, amount consumed, and if referral is indicated.
d. STD/HIV- if yes, please indicate infection/disease, if currently undergoing treatment or if treatment is completed.
e. Hepatitis - if yes, please indicate infection/disease, if currently undergoing treatment or if treatment is completed. Document infant's receipt of HBIG.
f. Prenatal Care - if, yes please indicated week that prenatal care began. If no, document mother's statements concerning same.
g. GBS/Group B Strep - if yes, please indicate treatment received, including the type of treatment.
h. Tobacco - if yes, please document the type, amount, and how often used (includes electronic nicotine devices/ vaping, chewing tobacco, snuff, etc.).
i. Rx/OTC/prescriptions/over the counter - if yes, please document in this section or in the medication section of the EHR. (If you document in the medication section of the EHR please note in this area.)
j. Prenatal Complications - if yes, document complications per patient report or other data as available.

3. Labor & Delivery

This section must be completed entirely as indicated in the electronic health record. Indicate whether data was obtained through patient record or by patient report. Please indicate if patient had or had no complications during labor and delivery. Indicate whether patient delivered full-term infant with no complications or problems identified and document any problems that may have occurred.

4. Well-being (Present/Not Present)

This section must be answered with more information than present/not present. Nurse must document assessment in free text area.

a. General Well Being - appearance should be appropriate (groomed, bathed, hair brushed, teeth brushed and not disheveled). Patient verbalizes and appearance indicates the ability to care for self. Patient is able to name agencies in the area that needs are identified.
b. Emotional Status - responds to questions appropriately; interacts with nurse/engaged in the visit; not distant; interacts with infant well, bonding appropriately by holding, caressing, touching infant, smiles at infant.
c. Physical Activities/Fatigue - document what physical activities that the mother is currently doing. Is she beginning to resume pre-delivery activities or pre-pregnancy activities? Is the mother fatigued or is she resting?
d. Blues/Depression - patient states and demonstrates no signs or symptoms of depression. Edinburg Depression Scale score <12 overall with question #10 score of "0". Edinburg Depression Scale is completed on every postpartum patient during the home visit. Nurse visualizes good interaction with baby and patient voices adjustment to new role.

5. Breastfeeding (Yes/No)

Denies any problems with breastfeeding. Reports good support system in place. Denies any breast tenderness, soreness, and engorgement. No signs or symptoms of mastitis reported to the nurse. Documentation in the EHR must support above information or indicate any deviation from normal expected answers.

a. Is client breastfeeding? Answer appropriately per clients report.
b. Support Systems/Resources Available - if yes, please document.
c. Any Complications or concerns - if yes, please document and
d. Other - any additional documentation as needed.

6. Home/Social Environment (Normal/Abnormal)

Information may be obtained through patient report and/or nurse observation. The nurse must document the result of the assessment/observation.

a. Type and condition of dwelling - must document findings.
b. Cleanliness - non-judgmental documentation of home.
c. Stove & refrigerator - are they present and working?
d. Basic family needs for clothing met – document if a lack of clothing and refer to appropriate agency for resources.
e. Environment/Safety hazards - if any safety hazards are noted a referral is made to the appropriate agency (Environmental Health, Division of Social Services, Fire Department, etc.).
f. Smoke/carbon monoxide detectors - are they present and working? If not, patient is informed of how/where to obtain these items? Every home does not need a carbon monoxide detector depending on heat.)
g. Number in household –
    1) Number of adults
    2) Number of children
h. Water supply/plumbing (source) - note whether well or city water.
i. Smoking (home/car) - no one smokes in the house or car. Offer 5 A's counseling and document.
j. Electricity - Is it working/adequate? If not, assist with finding the appropriate referral for services, i.e. Division of Social Services or other agencies that may assist with funding and document in the system.
k. Other - no physical hazards are noted in the home. If none, document. If hazards are noted, document and provide appropriate referral.

7. <u>Nutritional Status (Normal/Abnormal)</u> Through patient report and/or nurse observation:

a. Appetite - determine the amount of food that mother is taking in. If mother is breast feeding and is not taking in at least the amount of food that she was during pregnancy counsel mother. Refer to Public Health Nutritionist as indicated.
b. Adequate food supply - document mother's report of amount of foods available. Refer to WIC as necessary.
c. Vitamin/mineral supplement - continue taking vitamins as per physician recommendations.
d. Fluid intake - indicate the amount of fluid that mother reports ingesting. Recommend intake of 64 ounces daily of fluid, preferably water. Refer to nutritionist as indicated.

8. Elimination (Present/Not Present)

   a. Voiding/Bowel - the nurse documents: mother reports no problems and elimination habits are returning to pre-pregnancy state by the 3rd post-partum day; patient reports no pain or burning upon urination. If problems are present, document and refer mother to Obstetrician/ Gynecologist or appropriate referral source.
   b. Hemorrhoids - if present, has the Obstetrician (OB) given instructions and is the patient following instructions? If necessary contact the OB for additional instructions. Recommend sitz baths 2-3x daily.

9. Post-Partum Assessment (Normal/Abnormal)

   Per latest State form, WNL per patient report may be all that is required in certain areas of the assessment. If WNL or WNL per patient, refer to "normal" in Home Visit for Postnatal Assessment and Follow-Up Care Protocol attached.

   a. General Appearance - appearance should be appropriate (groomed, bathed, hair brushed, teeth brushed and not disheveled) and documented.
   b. Breast/Nipples – patient reports no complaints of cracked, bleeding nipples, engorgement, or other problems (WNL per patient). If abnormal assessment document findings and follow-up with physician or lactation consultation in WIC.
   c. Uterus - document fundal height and tone-palpation assessment of fundal height and tone beginning on the second post-partum day (expected finding: height decreases 1 cm every day and by post-partum day 10-14 the fundus in no longer palpable. When palpable the fundus should be firm).
   d. Episiotomy/Perineum - patient denies painful urination, edema, or burning (WNL per patient). If abnormal assessment document findings and follow-up as appropriate.
   e. Other - document any other problems that mother informs nurse about or the nurse observes during visit.
   f. Take vital signs T/P/R BP - vitals will return to pre-pregnancy baseline, i.e., blood pressure will return to pre-pregnancy baseline or be age appropriate. Refer for

abnormal as indicated (temp $\geq$ 99.0^{0}F; BP $\geq$ 20% of pre-pregnancy or perinatal baseline).

g. Abdomen/Incisions - per nurse observation, cesarean incision has healed by day seven. No signs or symptoms of infection (no redness, edema, exudate or fever). Report to the physician any abnormal findings. Document finding and any referral made.

h. Lochia- The color should be one of the following: Rubra-red and be present days 1-3; Serosa- pink/brown and be present days 4-10; Alba- yellowish/white and may be present up to 6 weeks post-partum (then WNL per patient). Any abnormal finding should be documented. The nurse should notify the physician of any abnormal finding.

i. Legs - per nurse's observation, no edema, negative Homan's Sign, pedal/posterior tibial pulses present and normal. Notify physician of any abnormal finding. The nurse should document the observation/assessment and if physician was notified.

j. Assess and instruct mother on the benefits of daily postpartum exercises.

10. Family Relationship (Normal/Abnormal)

The nurse must document information in the free text area. Normal/Abnormal is not considered complete and accurate documentation.

a. Support Person
b. Sexual Issues
c. Maternal Infant Bonding
d. Domestic Violence

11. Contraception

Complete this section in its entirety and include whether the mother has resumed sexual activity and/or what birth control method she is using, if any. Patient should report no sex until six week check-up. Counsel on the need for OB physician to release patient and for patient to resume sexual activity.

12. Referral (No/Yes)

Indicate if the client has a referral or needs a referral to each of the following agencies/services. If an appointment is scheduled

please indicate the date of the appointment. If client needs a referral the nurse indicates this in the note with the referral information that has been given.

a. WIC
b. Post-Partum Exam
c. Breast feeding support
d. Parenting classes
e. Medicaid BeSmart for FP services
f. Other
g. Medicaid
h. Family Planning
i. CMARC
j. Transportation
k. Newborn assessment complete

13. Coordination of services

Please complete this section in its entirety, adding more information as indicated based on the need after the assessment is completed. If mother and/or child are currently receiving care management services, coordinate care to avoid duplication of services.

14. Finalizing

a. Review summary and other data as indicated for accuracy.
b. Select a visit code
c. Assign note area should indicate person documenting/ making note
d. Select Save Button
e. Select Education (note in the system any education that was given to the mother in the "plan of treatment" area of the electronic health record).
f. Select ESB
g. Sign and Lock the note.
h. Turn in billing to the appropriate staff to complete.

See attached state protocol for postpartum visit.

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Home Visit for Postnatal Assessment and Follow-up Care Protocol

Prior to visit the following should be completed:
1. Complete demographic information required.
2. Review of prenatal (PN) and Intrapartum history (Hx)
3. Contact Care Manager to assess any medical problems that would require a further discussion or a referral during the visit.

If mother is non-English speaking, it would be preferred to have an agency approved interpreter present during the visit. If an interpreter's presence is not possible, please note who performed the interpreting.

NOTE: Medicaid requires that form codes be used under the form's code column section.

Parameters of Assessment	Outcome Criteria	Constraints	Nursing Process
I. Prenatal History			B. Document by weeks/days when Prenatal Care (PNC) began. Assess by record. C. Review and/or asking mother specific use of: Tobacco, products, electronic nicotine devices/vaping, alcohol, illegal drugs, prescription and over-the-counter (OTC) drug or herbal supplements/remedies. D. Sexual transmitted infections (STI) and Human Immunodeficiency Virus (HIV) E. Group B Streptococcus (GBS) - if patient was GBS positive, document treatment F. Hepatitis - if patient was positive, document infant's receipt of HBIG G. PN complications - if yes, explain
II. Intrapartum	Mother had an uneventful/positive experience intrapartum		A. Gravida: record total number of pregnancies. Parity: First entry is number of Term pregnancies (37 weeks or greater of gestation); second entry is number of Preterm pregnancies (36 6/7 weeks or less of gestation); third entry is number of miscarriages and/or spontaneous/therapeutic abortions; fourth entry is number of current living children. D. Assess by record review and/or asking mother specifics of intrapartum and postpartum course of care. E. Immunization(s) received post-delivery. (i.e., Influenza, Rubella (MMR), Tetanus, Diphtheria, and Pertussis vaccine (Tdap), and Varicella)

Parameters of Assessment	Outcome Criteria	Constraints	Nursing Process
III. Interim	Mother states and/or demonstrates time for her personal self	- Pre-existing mental illness or intellectual disability - Previous postpartum depression. Infant loss, birth defect, prematurity or adoption may modify mother's postpartum emotional reaction. - Other issues, which may affect adaption to role include: unwanted pregnancy, difficult intrapartum course, poor support system, Cesarean section, drug use during and/or after pregnancy.	Assess by record review and/or asking mother specifics in regards to: A. General wellbeing (subjective) B. Physical activity/fatigue; support person(s) in place, rest she is receiving, diet, exercise C. Emotional status; feeling regarding motherhood, affect and interaction with infant D. Blues/Depression; PHQ9 or EDPS screening performed, scored, documented, and referral made if indicated. 1. Postpartum blues a. Lasts 3-7 days b. Due to hormonal changes, discomfort or fatigue c. Usually temporary
IV. Infant Feeding	Mother is breastfeeding comfortably, if applicable, or bottle-feeding as appropriate. Nursing at least every 2-3 hours during the day/night.	Not breastfeeding	Assess by record review and/or asking mother specifics in regards to: C. Complications/concerns: Is mother having any problems with sore nipples, engorgement, pumping or any other concerns? Inquire about frequency of feedings, and/or supplemental formula. Observe a feeding to determine the following: correct positioning of infant, latch-on, strength of suck and swallow. Ensure proper preparation/storage of breastmilk. If bottle feeding, note any issues with formula preparation, feeding and/or need for referral. D. Support/resources available: Ensure that mother has written breastfeeding references titled "Breastfeeding: a Mother's Gift" or a book from Women, Infants and Children (WIC) lending library. - Inform mother of breastfeeding support available in the community (peer/ lactation counselors, support groups, and telephone help).
V. Home Environment	- Family is living in a home that is adequate in space, cleanliness and repair. - Family has adequate equipment to safely prepare and store food. - Family can meet basic needs.		Assess by observation and/or asking mother specifics in regards to: B. Number in household: Overcrowding? C. Adequate source of income D. Water supply/plumbing: Access indoor and/or outdoor? E. Basic family needs for clothing met? F. Stove and refrigerator: If equipment is present and in proper working condition. G. Electricity: Is it available/turned on? H. Environment/Safety hazard(s): Home environment has physical hazards? I. Smoking: Is the mother a smoker or anyone in the infant's home? Do they smoke inside the home or car? J. Smoke/Carbon Monoxide detectors: Present and in compliance with the square footage of home? May need multiple units.

Parameters of Assessment	Outcome Criteria	Constraints	Nursing Process
VI. Nutritional Status	- Mother's appetite is normal - Family has access to an adequate and safe food supply.		Assess by observation and/or asking mother specifics in regards to: A. How is the mother's appetite? Report on how many meals/snacks mother consumes in a day in relation to the amount she ate before her pregnancy. B. Recommend continuing prenatal vitamins through postpartum and possibly beyond if breastfeeding. C. If applicable, inquire with the mother when the next WIC appointment is and assist with scheduling if needed. Provide other resources for food assistance. D. Recommend intake of 64 ounces daily of fluid water (preferably water). Provide counseling during home visit if area(s) of need are identified. If more significant issues are identified, refer to public health nutritionist and/or pregnancy care manager.
VII. Elimination	Mother is voiding and bowel pattern are within normal limits (WNL) with little to no discomfort.		Assess by record review and/or asking mother specifics in regard to: A. Voiding/Bowel function; determine adequacy of fiber and fluid intake. Note: if constipation is an issue, provide counseling that suggests increasing fiber and fluid intake. B. Hemorrhoids; If hemorrhoids are present suggest sitz baths 2-3x daily. Contact provider for a prescription for a stool softener and witch hazel pads to be applied to the affected area.

Parameters of Assessment	Outcome Criteria	Constraints	Nursing Process
VIII. Postpartum Physical Assessment	- Mother demonstrates or states that she is progressing through the postpartum period WNL. - Little to no edema is present. - Blood pressure (BP) has returned to pre-pregnancy or PN baseline reading. - Breasts have little to no engorgement and/or tenderness by three weeks. - Cesarean incision has healed by 7 days. - Rubra lochia has ceased by one week. - Mother has increased her activities of daily living (ADL) gradually guided by her level of tolerance. Mother will perform appropriate postpartum exercises daily.	Pre-existing medical condition Delivery was vaginal If Cesarean delivery and Tubal ligation, follow Provider's guidance for beginning to engage in exercise.	Note: Please indicate whether significant problem or no significant problem was identified for each component. Assess physical status: A. General Appearance B. Take full set of vital signs (VS) and record. Compare pre-pregnancy or PN baseline BP to current findings. Inquire and inspect: C. Breast/nipples D. Abdomen (surgical incision) E. Uterus (location) F. Lochia (color, amount, odor) G. Perineum/episiotomy (healing, swelling) H. Legs (edema, pain) I. Other Instruct mother in regards to: - Cleansing perineum well, front-to-back after each toileting with peri pad changes. - Keeping bladder empty assists with decreased bleeding and cramping. - Lying in a prone position helps to ease cramping - If not breastfeeding wear supportive bra continuously. Ice pack(s) may help to relieve breast engorgement discomfort. Avoid stimulation of nipples. Provider referral: - Leg edema beyond one week - Pain in leg(s) - A temperature of 99.0°F or 37.2°C or greater - BP elevated ≥ 20% of pre-pregnancy or PN baseline findings - Painful lump(s) in breast(s) - Signs of infection - Excessive bleeding with/without clots beyond one week. - Foul smelling discharge - Abdominal Pain - Burning with urination Assess and instruct mother in regard to: - Knowledge of the benefits of daily postpartum physical exercise 1. Promotes healing 2. Enhances circulation 3. Assists with return to pre-pregnancy weight 4. Enhances physical recovery during involution of the uterus. 5. Improves self-esteem and attitude

Parameters of Assessment	Outcome Criteria	Constraints	Nursing Process
			- Exercises 1. Kegel exercises may be started immediately after birth regardless of the type of delivery. *2. Pelvic rock *3. Modified sit ups *4. Bent leg lifts * Begin slowly and build up to maximum repetitions by 6th week.
IX. Family Relationships	- Mother moving toward a satisfying, comfortable relationship with infant and if applicable significant other (SO). - Resumption of sexual relations with SO and without discomfort - Interpersonal Violence is identified and resources shared with mother.	- Stillbirth/miscarriage or baby up for adoption (BUFA). - Other issues in parent-infant interaction may be in part to infant with special medical or developmentally anticipated needs. i.e., Neonatal intensive care unit (NICU) admission; congenital anomaly, chromosomal abnormality. - Not having sexual relations. - If perineum has not yet healed. - Privacy for open discussion.	Assess by observation and/or asking mother specifics in regards to: A. Those person(s) assisting mother in caring for infant B. Maternal-Infant bonding: - Demonstrate, if needed – how to interact with infant: 1. Establish eye contact 2. Hold closely, touch, stroke and rock gently 3. Talk and/or sing to infant - Identify to mother where infant is in developmental growth, and perhaps what is in the near future (milestones to look for). Assess by asking mother specifics in regards to: C. Sexual issues - Advise to avoid intercourse until postpartum exam. Advise that coital, side lying or female superior positions are those in which the woman has control of the depth of penile penetration and are often recommended regardless of the type of delivery experienced. - If some vaginal tenderness is present, the SO can be instructed to insert one or more clean, lubricated fingers in to the vagina and rotate them within it to facilitate relaxation of the muscle while possible identifying areas of discomfort. - Kegel exercises assist with vaginal perception and response during intercourse. - Vaginal dryness may occur and a lubricant might be needed (water soluble gel, contraceptive cream) D. Interpersonal Violence; observe behavior of mother and others in her environment. Inquire about safety issues and provide resources if appropriate.

Parameters of Assessment	Outcome Criteria	Constraints	Nursing Process
X. Contraception	- Mother is able to articulate use of chosen method of contraception. - Mother does not experience an unplanned pregnancy. - Any future pregnancies are planned.	- No method chosen; bilateral tubal ligation. - No contraceptive method is acceptable. - Lack of resources and not using effective method of birth control.	Assess by asking mother specifics in regards to: A. Current method; mother and SO's (if applicable) understanding and use of selected method of contraception. Provide information as needed. B. Planned method; mother has postpartum examination within 4-6 weeks of delivery with plans to receive method if didn't receive one prior to hospital discharge. C. Plans for Spacing Children - Mother's knowledge: 1. Regarding reasons for family planning (FP) including physical, emotional, financial and social aspects. 2. Of birth control methods, while assisting her in future planning. 3. The potential impact of FP methods on lactation (if applicable). 4. Encourage her to discuss FP methods with SO 5. Review the choices of both temporary and permanent methods.
XI. Referrals	Mother recognizes need for preventative care for herself.		Assess by asking mother specifics in regards to: - Already planned or needed appointments. - Needing information about particular program(s).
XII. Coordination of Services	Collaboration and information sharing with pregnancy care manager and care management for children care manager as indicated.	- Patient not receiving care management services. - No needs identified by care managers. - Mother declines care management referral(s) for identified need(s).	Review Division of Medical Assistance (DMA) Clinical Coverage Policy No.: 1M-5 Home Visit for Postnatal Assessment and Follow-up Care (Amended: December 20, 2019 or latest revision), 5.4 Other requirements. If mother and/or infant are currently receiving care management services, coordinate care to avoid duplication of services: - Prior to visit, discuss past and present medical history (Hx) of mother and infant with care managers. - Discuss, develop and/or revise care plan(s) with care managers as applicable. - Following the visit; document findings in both mother and infant's medical record. - Discuss visit observations/concerns with care manager as applicable.

Abbreviations:

Baby Up For Adoption (BUFA)
Blood Pressure (BP)
Division of Medical Assistance (DMA)
Family Planning (FP)
Group B Streptococcus (GBS)
History (Hx)
Human Immunodeficiency Virus (HIV)
Neonatal Intensive Care Unit (NICU)
Over-the-Counter (OTC)
Prenatal (PN)
Prenatal Care (PNC)
Sexual Transmitted Infection (STI)
Significant Other (SO)
Within Normal Limits (WNL)
Human Papilloma Virus (HPV)
Vital Signs (VS)
Verbal Numeric Rating Scale (VNRS)
Family Planning (FP)
Obstetric Care Manager (OBCM)
Care Coordinator For Children (CC4C)
Tetanus, Diphtheria, and Pertussis Vaccine (Tdap)

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NEWBORN ASSESSMENT HOME VISIT PROTOCOL

DATE DEVELOPED: 5/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/24

I. POLICY:

The Division of Public Health Services Nurse will provide home visits to newborns who reside in Rockingham County **and neighboring counties** and will adhere to the North Carolina guidelines for newborn care and assessment protocol.

II. PURPOSE:

Newborn home visits provide a health assessment of the newborn post discharge from the hospital. Newborn home visits promote and provide a timely referral of problems and improve the health of the newborn.

III. GUIDELINES:

See attached state protocol for newborn visit.

Rev/di

PROTOCOL: Home Visit for Newborn Care and Assessment

Demographic Information	
Outcome Criteria	**Nursing Process**
□ Newborn Home Visit Assessment Record is complete for billing purposes. □ As appropriate, the child's Newborn Home Visit Assessment may be included in the child's medical record.	◊ Documentation of: • Name, Date of Birth, Race/Ethnicity, Gender, Age at Visit • Patient Identification/Medicaid Number • County of Residence • Address, Telephone Number, Directions to the Home • Primary Language Spoken in the Home; Interpreter Needed/Interpreter Signature • Documentation of whether the visit was conducted in-home or via Telemedicine due to COVID-19 • Location of mother and infant • Location of provider delivering the service • Documentation of system used to deliver Telemedicine visit (i.e., Doxy.Me, Doximity)

Maternal/ Family Demographics; Risk Factors Identified	
Outcome Criteria	**Nursing Process**
□ Maternal/Family demographic risk factors are identified	◊ Assessment: • Mother's Name • Mother's Identification Number • Mother's Date of Birth, Marital Status • Mother's Education; Mother's Employment Status • Father's Involvement • Other Primary Caretaker(s) ◊ Referral • As indicated by risk factors known to be present, or found during the visit • Finding provided to other service providers <u>with</u> parental consent

PROTOCOL: Home Visit for Newborn Care and Assessment

I. Home & Social Environment	
Outcome Criteria	**Nursing Process**
□ Infant is living in a home that is adequate in space, clean, safe, and in good repair	◊ Assessment: • Type and Condition of Dwelling • Number of Adults and Children in the household; including the adequacy of space for the number of people living there • Cleanliness • Safety Hazards, (Include in this assessment such things as peeling paint or other lead hazards; missing window screens; window blind cords near the crib; spaces between crib slats less than 2 3/8 inches, obvious fire hazards, walkers, community safety concerns) • Smoke Detector, Carbon Monoxide Detector • Smoking, vaping or other tobacco use in the home and the car ◊ Referral: • As indicated by obvious safety hazards ◊ Education: • Safety Risks • Lead Poisoning Risks • Smoking, Vaping or Tobacco Hazards • CMV?
□ Infant is living in an environment that supports ongoing social-emotional development.	◊ Assessment: • Alcohol or drug use by mother, other family members, or other household members • Domestic Violence in the home • Mental health issues in mother, family or resident in the home ◊ Referral: • As indicated by risk factors known to be present or found during the visit • Finding provided to other service providers <u>with</u> parental consent ◊ Education: • Anticipatory guidance around development and future screenings in the medical home

□ Caregiver has adequate equipment to safely care for infant and to prepare and appropriately store breastmilk, formula or food.	◊ Assessment: Are the following available and working/adequate? • Type of Water Supply/Indoor Plumbing • Stove • Refrigerator • Electricity(include heat, air conditioning, heat and/or fans • Telephone (If no telephone, discuss the emergency plan, and contact numbers) • Smoke/Carbon Monoxide Detectors • Car Seat (Understands correct use/placement)

II. Perinatal History: Risk Factors Identified	
Outcome Criteria	**Nursing Process**
□ Perinatal medical risk factors are identified	◊ Assessment: • Prenatal Complications; Labor/Delivery Complications • Postpartum Complications • Mother's Mental Health and Well-Being; "Blues"; Depression, Anxiety, Diagnoses and Treatment • Gestational Age • Birth Measurements – Weight, Length; and Head Circumference (if available) • Status of Newborn Hearing Screening and Metabolic Screening • Maternal CMV status?

III. Infant Nutrition	
Outcome Criteria	**Nursing Process**
□ Breastfed infant receives adequate nutrition.	◊ Assessment: • Number of feedings in 24 hours • Average length of feedings • Infant is Content After Feeding
□ Formula-fed infant receives adequate nutrition	◊ Assessment: • Formula Type; Amount per 24 hours; Formula Preparation • Adequacy of Bottle Supply • Infant is Content After Feeding
□ Family has adequate physical material and educational resources related to infant feeding.	◊ Assessment: Observe/Inquire about signs that breastfeeding is progressing well <u>Breastfed</u> • Infant has at least six wet diapers per day • Infant is having at least one stool per day after the 4th day of life • Weight gain per expected parameter *Infant gains 4-7 ounces per week after regaining birth weight by 10 days of age* • Mother feels tug, not pain during feedings • Infant swallows hard after first few strong sucks • Mother's concerns/problems and supports related to breastfeeding

PROTOCOL: Home Visit for Newborn Care and Assessment

III. Infant Nutrition (continued)	
Outcome Criteria	**Nursing Process**
□ Family has adequate physical material and education resources related to infant feeding. □ Infant receives adequate nutrition. □ Family has adequate educational resources related to infant feeding.	◊ Assessment: Observe/Inquire about the adequacy of intake: <u>Formula Fed</u> • Infant has at least six wet diapers per day • Infant is having at least one stool per day after the 4th day of life • Weight gain per expected parameters ▪ *Infant gains 4-7 ounces per week after regaining birth weight by 10 days of age* ◊ Family Education: Suggested Materials: • *Breastfeeding Promotion and Support Guidelines for Healthy Full-Term Infants* • *Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents, Second Edition, Revised* • *Bright Futures in Practice: Nutrition* Learn the Signs Act Early (CDC • Reach Out and Read • Safe Sleep • CMV Prevention? ◊ Referral: For abnormal or suspicious findings/additional education/breastfeeding assistance or peer support: • Patient/Family Counseling • WIC Program • Lactation Consultant

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PROTOCOL: Home Visit for Newborn Care and Assessment

IV. Basic Care/Caregiver Skills	
Outcome Criteria	**Nursing Process**
□ Caregiver has adequate material resources to provide safe care. □ Caregiver has adequate skills to meet infant's basic physical needs.	◊ Assessment: The family has at least the following resources in adequate amounts for the care of this infant: • Bottle Supply/Formula Preparation (Also refer to Infant Nutrition Parameter) • Breastfeeding supplies as needed??? • Oral Health • Diapers/Diapering • Clothing • Bassinet/Crib • Thermometer • Bathing/Cord Care • Handling/Positioning ("Safe sleep + SIDS") - Bulb suction - ◊ Referral: • Assist families with obtaining basic care resources ◊ Assessment: Observe/Discuss to assess knowledge: *Feeding: Formula Preparation • Assess for appropriate dilution of concentrated or powdered formula • Caregiver does not use the microwave to warm bottle due to risk of scalding newborn's palate *Diapers/Diapering • Caregiver changes diapers frequently (does not reuse disposable diapers *Clothing • Caregiver dresses infant appropriately for the season, room temperature & do not overheat as this increases the risk for SIDS *Thermometer • Assess for correct use of a thermometer, including the ability to read the thermometer *Bathing/Cord Care • Observe care of cord during diaper changes; if cord clamp in place have removed • Caregiver gives tub bath only after cord heals • Caregiver understands how to safely bathe infant (never leave unattended, check the temperature of bath water, etc)

PROTOCOL: Home Visit for Newborn Care and Assessment

1V. Basic Care/Caregiver Skills (Continued)	
Outcome Criteria	**Nursing Process**
□ Caregiver has adequate skills to meet infant's basic physical needs. □ Caregiver gains adequate knowledge and skills to provide safe care to an infant.	◊ Assessment: Observe/Discuss to assess knowledge: *Safe Handling/Positioning - Observe handling and placement of the infant - Caregiver places the infant into a properly secured car seat safely (rear-facing seat in the back of vehicles) - Caregiver follows "Safe sleep" recommendations (unless medically contraindicated) to reduce the risk of SIDS ◊ Education: As indicated, demonstrate and teach: • Formula Preparation, as needed (dilution, safe warming and handling) • Diapering; Circumcision Site Care • Dressing infant appropriately for the season, environment • Crib Safety • Use of pacifier (including "safe sleep" + SIDS risk reduction) • Use of Infant Car Seat • Temperature taking/Reading a Thermometers • Bathing/Cord Care • Safe Handling/Placement of infant • Recognition of Signs and Symptoms of Illness • Use of bulb syringe • CMV prevention strategies

PROTOCOL: Home Visit for Newborn Care and Assessment

V. Parenting Skills	
Outcome Criteria	**Nursing Process**
□ Caregiver forms an appropriate attachment to infant and stimulates infant's development	◊ Assessment: Observe the interaction between infant and parent when the infant is not crying: • Holding and cuddling • Touching and stroking • Eye contact • Talking and singing • Rocking and swaying • Skin-to-skin contact
□ Caregiver responds to infant's cues appropriately.	◊ Assessment: Observe caregiver's response to infant's cues: • Provides stimulation during alert periods • Discontinues stimulation when infant withdraws • Investigates and intervenes when infant manifests distress • Responds appropriately to crying ("Shaken Baby Syndrome) • Recognizes cues for hunger
□ Caregiver and infant will interact in a reciprocal manner.	◊ Assessment: Observe caregiver(s) and infant during feeding, if possible
□ Infant is integrated as a family member.	◊ Assessment: Observe other family members as they interact with the infant
	◊ Education/Counseling: • Infant can see, hear, and move from birth • Suggest appropriate stimulation techniques which include reading, singing and talking • Discuss how to respond to infant's engagement and disengagement cues
	◊ Referral: For abnormal or suspicious findings: • CMARC (Care Management for at-risk children) • PCP • Other agencies as appropriate

PROTOCOL: Home Visit for Newborn Care and Assessment

V1. Newborn Assessment	
Outcome Criteria	**Nursing Process**
□ Infant is growing and developing appropriately. NOTE: This assessment consists of a brief physical inspection using the skills of observation and palpation and auscultation. Registered Nurses performing this appraisal are not required to be rostered as Child Health Nurse Screeners. Equipment needed includes unless done via telehealth): - Infant Scales - Measuring Tape - Thermometer (as needed) - Stethoscope (pulse rate may be measured apically) or palpated brachially. Findings indicated in *ITALICS TYPE* necessitate <u>Immediate</u> <u>Referral</u> to the infant's health care provider Other findings not considered to be "Within Normal Limits" should be discussed with the caregiver; arrangements should be made for timely follow-up on abnormal or suspicious findings. □ Caregiver is aware of any special physical needs of baby and provides adequate care.	◊ Assessment: Nursing Inspection/Observation of Unclothed Infant: including: *Vital Signs *Fever≥ 100.6 Rectally*, heart rate and respiratory rate *Elimination Void - # wet diapers in 24 hours, color, odor Stools - # in 24 hours, color, consistency *Fontanels Open/Closed, *Bulging or Sunken* *Skin Intact/Hydrated, *Jaundice, Rashes* *Mouth Symmetry, Lips and Palate Intact *Eyes Regards Face; Follows Face or Light *Hearing Startles to Loud Noise (Moro Reflex), Calms/ Attends to voice *Breast Engorgement, Drainage *Heart/Lungs Heart and Respiratory Rates *Abdomen Soft/*Rigid, distended*/flat *Cord Off/On, Healing/Drying, *Drainage*, clamp not present *Genitalia Male-Circumcision Healing Female-Discharge *Reflexes Root, Suck, Grasp, Fencing (ATNR) *Development Lifts Head, Vocalizes, Moves all Extremities *Extremities Complete Movement *Wake/Sleep Establishing pattern, Awakens at Night to Feed *Other Other findings not "Within Normal Limits" ◊ Education • Counsel on normal and abnormal findings ◊ Referral • For abnormal or suspicious findings ◊ Assessment: • Knowledge and skill in caring for any special needs of an infant ◊ Education: • Demonstrate and teach caregiving skills as needed. Use the Teach Back method.

PROTOCOL: Home Visit for Newborn Care and Assessment

VII. Resources and Referrals	
Outcome Criteria	**Nursing Process**
□ Caregiver recognizes the need for routine preventive Well Infant/Child Health care through a medical home.	◊ Assessment: Assess caregiver's knowledge of and plans for: ○ Well Infant/Child Health Care (Does the infant have an appointment scheduled?) ○ Medical Home (Has caregiver identified medical provider for the ongoing need for health care ?) ○ Immunizations (Did the infant receive immunizations prior to hospital discharge? Does the infant have an appointment scheduled?) ○ Health Insurance/Medicaid(Does the infant's family have a payor source or funds to pay for health care services?) ◊ Referral As needed, assist the family with: • Scheduling appointments • Selecting health care provider • Obtaining payor source for health care
□ Nurse and Caregiver will discuss family's needs.	◊ Assessment: See problems and concerns already identified during the *Newborn Home Visit Assessment*
□ Caregiver will be informed of resources available to address unmet needs or concerns.	◊ Resources/Referrals: Provide appropriate information to the caregiver and/or initiate referrals with input from the caregiver. All referrals <u>are</u> <u>contingent</u> upon the family's consent. • WIC Program • Medicaid//Prepaid Health Plan • Quality Child Care (If needed, does the family have a provider identified? Is assistance needed with locating safe, appropriate childcare services? Does the family need information about childcare subsidies?) • Transportation • CMARC • CMHRP (Care Management for High-Risk Pregnancy) /Maternal Outreach Worker • CDSA/Infant Toddler Program (Part C Early Intervention) • As identified by family (Department of Social Services or NC 211; Food Stamps/EBT benefits, utility, rental payment or housing needs (i.e., quarantine or isolation due to COVID-19), etc.)

VII. Resources and Referrals (Continued)	
Outcome Criteria	**Nursing Process**

□ Nurse making Newborn Home Visit Assessment collaborates with the CMHRP or CMARC Care Manager (*If Applicable*).	◊ *See North Carolina Clinical Coverage Policy 1M-4 Home Visit for Newborn Care and Assessment December 2019*
	
	An RN who is not a CMHRP Care Manager or CMARC Care Manager is required to coordinate services, when applicable.
	• *discuss the past and current medical history of the mother and child with the CMHRP Care Manager and/or CMARC Care Manager;*
	• *discuss the plan of care or service coordination goals with the CMHRP and/or CMARC Care Manager prior to the home visit, so that tasks listed in the plan of care can be addressed during the home visit; and*
	• *contact the family to schedule a convenient time for the home visit and to explain its purpose.*
	
	Following the home visit for newborn care and assessment, the RN must:
	• *document findings in the mother's record and in the child's record as they apply;*
	• *discuss observations with the CMHRP Care Manager and/or CMARC Care Manager; and*
	• *update the CMHRP Care Management and/or CMARC plan of care, as applicable.*
	
	◊ *NBHVCA visits conducted via Telehealth:*
	NC Medicaid encourages local health departments to provide maternal support services in-person when it is safe to do so; however, if an in-person or home visit is not feasible, eligible providers may conduct maternal support services with new or established patients via telemedicine (two-way real-time, interactive audio-video).
	
	• Maternal support services conducted via virtual patient communication (telephone, virtual portal communications, etc.) will not be eligible for reimbursement.
	• Eligible maternal support services include:
	  • Home visit for newborn care and assessment
	  • Home visit for postnatal assessment
	  • Childbirth education classes (individual or group classes)
	• Eligible providers include local health departments whereby the service is rendered via telemedicine by:

	• A registered nurse (for a home visit for newborn and postnatal assessment, only); or, • A certified childbirth educator (for childbirth education classes, only). • For the newborn assessments, providers must document on the assessment tool that the service was conducted via telemedicine. • See NC Medicaid Clinical Coverage Policies 1M-4; https://files.nc.gov/ncdma/documents/files/1M-4_0.pdf for further details and guidance regarding the delivery of these services. • Patients are not required to obtain prior authorization prior to receiving services via telemedicine.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: POSTPARTUM DEPRESSION SCREENING

DATE DEVELOPED: 5/07
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16; 6/18

I. POLICY:

The Division of Public Health Services Postnatal Nurse will provide postpartum depression screening to PCM/postnatal clients using the Edinburgh Postnatal Depression Scale (EPDS).

II. PURPOSE:

To identify early signs and symptoms of possible postpartum depression and assist clients with obtaining further assessment and/or treatment.

III. GUIDELINES:

A. All clients who receive a postnatal home visit assessment will be screened with the EPDS tool.

B. When the EPDS is administered, the client should complete it in a quiet atmosphere away from family and friends. If the client is unable to read and/or understand the EPDS, the Postnatal Nurse will assist her.

C. Scores of 9 or greater should alert the Postnatal Nurse to the possibility of postpartum depression. Scores of 12 or above should serve as a "red flag" that postpartum depression is highly probable, and therefore an extra measure of attention and concern is warranted.

D. If the client has a low risk score but answers question #10 with a "yes" or "sometimes", she will be considered at high risk for immediate intervention.

E. Clients at high risk for suicide or danger to others will require the Postnatal Nurse to assess available support from family members to assist client in obtaining immediate mental health services. Postnatal Nurse will contact client's obstetrician and notify physician of above findings and request direction for intervention.

F. If no appropriate care provider (family or friend) is available to stay with the client, Postnatal Nurse will contact PHN Supervisor for approval to transport client to the hospital. If client is unwilling to be transported for evaluation at the hospital, with supervisory approval Postnatal Nurse will contact the police for further assistance.

G. Clients with scores of 12 or greater will be referred to their obstetrician for evaluation. Postnatal Nurse will assist client with contacting physician while in the home and explaining screening results of EPDS.

H. Postnatal Nurse will assure that client has spoken with MD office and arrangements have been made for client's care prior to Nurse leaving the home or by the end of the business day. MD will make the decision on when the client is seen.

/di

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

Edinburgh Postnatal Depression Scale

1. Last Name First Name MI											
2. Patient SS#:				-			-				
3. Date of Birth	Month		Day		Year				4. Sex ☐ Male ☐ Female		
5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4, Asian ☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Unknown											
Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown											
6, County of Residence:											

As you have recently had a baby we would like to know how you are feeling. Please underline the answer which comes closest to how you felt in **the past 7 days**, not just how you feel today.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   A. As much as I always could.
   B. Not quite so much now.
   C. Definitely not so much now.
   D. Not at all.

2. I have looked forward with enjoyment to things
   A. As much as I ever did.
   B. Rather less than I used to.
   C. Definitely less than I used to.
   D. Hardly at all.

3. I have blamed myself unnecessarily when things went wrong
   A. Yes, most of time.
   B. Yes, some of the time.
   C. Not very often.
   D. No, never.

4. I have been anxious or worried for no good reason
   A. No, not at all.
   B. Hardly ever.
   C. Yes, sometimes.
   D. Yes, very often.

5. I have felt scared or panicky for no very good reason
   A. Yes, quite a lot.
   B. Yes, sometimes.
   C. No, not much.
   D. No, not at all.

6. Things have been getting on top of me
   A. Yes, most of the time I haven't been able to cope at all.
   B. yes, sometimes I haven't been coping as well as usual.
   C. No, most of the time I have coped quite well.
   D. No, I have been coping as well as ever.

7. I have been so unhappy that I have had difficulty sleeping
   A. Yes, most of the time.
   B. Yes, sometimes.
   C. Not very often.
   D. No, not at all.

8. I have felt sad or miserable
   A. Yes, most of the time.
   B. Yes, quite often.
   C. Not very often.
   D. No, not at all.

9. I have been so unhappy that I have been crying
   A. Yes, most of the time.
   B. Yes, quite often.
   C. Only occasion.
   D. No, never.

10. The thought of harming myself has occurred to me
    A. Yes, quite often.
    B. Sometimes.
    C. Hardly ever.
    D. Never.

(Scale designed by J.L. Cox, J.M. Holden, R. Sagovsky, Department of Psychiatry, University of Edinburg. Reprinted with permission from the British Journal of Psychiatry, 1987.)

How to score the Edinburgh Postnatal Depression Scale (EPDS)

Whenever possible, the patient should complete the EPDS in a quiet atmosphere away from friends and family.

Each question is given a score value from zero to three, with three suggesting a higher probability of depression. Thus, a score of 30 would be the maximum possible score.

Examples (point value in parenthesis):

1. I have been able to laugh and see the funny side of things

(0) A. As much as I always could.
(1) B. Not quite so much now.
(2) C. Definitely not so much now.
(3) D. Not at all.

(EPDS items 1, 2, and 4 are scored in this ascending order.)

3. I have blamed myself unnecessarily when things went wrong

(3) A. Yes, most of the time.
(2) B. Yes, some of the time.
(1) C. Not very often.
(0) D. No, never.

(EPDS items 3, 5, 6, 7, 8, 9 and 10 are scored in this descending order.)

Interpreting Scores: In studies validating the EPDS, when a cut-off score of 13 was used, a sensitivity of 95% and a specificity of 93% was reported. A sensitivity of 100% and a specificity of 82% was reported when a cut-off score of 10 was used.

Because the EPDS is a screening tool, a low cut-off score should be used to give sensitivity priority over specificity. Therefore, EPDS scores of nine or greater should alert the caregiver to the possibility of postpartum depression. Moreover, scores of 12 or above should serve as a "red flag" to the caregiver that the postpartum depression is highly probable, and therefore an extra measure of attention and concern is warranted.

REFERENCES:

Cox J, et al. Detection of postnatal depression: Development of the 10-item Edinburgh Post-natal Depression Scale. Brit J Psych 1987; 150:782-786.

Harris. et al. The use of rating scales to identify postnatal depression. Brit J Psych 1989; 154:813-817.

Murray l and Carothers A. The validation of the Edinburgh Postnatal Depression Scale on a community sample. Brit J Psych 1990; 288-290.

Escala Edinburgh para la Depresión Postnatal (Spanish Version)

Fecha:_____ Nombre de la Clínica/Número:_____

Su Edad: _____ Semanas de Embarazo/Edad del Bebé:_____

Como usted está embarazada o hace poco que tuvo un bebé, nos gustaría saber como se siente actualmente. Por favor MARQUE (√) la respuesta que más se acerca a como se ha sentido durante LOS ÚLTIMOS 7 DÍAS y no sólo como se ha sentido hoy.

A continuación se muestra un ejemplo completado:

Me he sentido feliz:

Sí, todo el tiempo	____ 0
Sí, la mayor parte del tiempo	✔ 1
No, no muy a menudo	____ 2
No, en absoluto	____ 3

Esto significa: "Me he sentido feliz la mayor parte del tiempo" durante la última semana. Por favor complete las otras preguntas de la misma manera.

1. He podido reír y ver el lado bueno de las cosas:

Tanto como siempre he podido hacerlo	____ 0
No tanto ahora	____ 1
Sin duda, mucho menos ahora	____ 2
No, en absoluto	____ 3

2. He mirado al futuro con placer para hacer cosas:

Tanto como siempre	____ 0
Algo menos de lo que solía hacerlo	____ 1
Definitivamente menos de lo que solía hacerlo	____ 2
Prácticamente nunca	____ 3

3. Me he culpado sin necesidad cuando las cosas marchaban mal:

Sí, casi siempre	____ 3
Sí, algunas veces	____ 2
No muy a menudo	____ 1
No, nunca	____ 0

4. He estado ansiosa y preocupada sin motivo alguno:

No, en absoluto	____ 0
Casi nada	____ 1
Sí, a veces	____ 2
Sí, muy a menudo	____ 3

5. He sentido miedo o pánico sin motivo alguno:

Sí, bastante	____ 3
Sí, a veces	____ 2
No, no mucho	____ 1
No, en absoluto	____ 0

6. Las cosas me oprimen o agobian:

Sí, la mayor parte del tiempo no he podido sobrellevarlas	____ 3
Sí, a veces no he podido sobrellevarlas de la manera	____ 2
No, la mayoría de las veces he podido sobrellevarlas bastante bien	____ 1
No, he podido sobrellevarlas tan bien como lo hecho siempre	____ 0

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:

Sí, casi siempre	____ 3
Sí, a veces	____ 2
No muy a menudo	____ 1
No, en absoluto	____ 0

8. Me he sentido triste y desgraciada:

Sí, casi siempre	____ 3
Sí, bastante a menudo	____ 2
No muy a menudo	____ 1
No, en absoluto	____ 0

9. Me he sentido tan infeliz que he estado llorando:

Sí, casi siempre	____ 3
Sí, bastante a menudo	____ 2
Ocasionalmente	____ 1
No, nunca	____ 0

10. He pensado en hacerme daño:

Sí, bastante a menudo	____ 3
A veces	____ 2
Casi nunca	____ 1
No, nunca	____ 0

Edinburgh Postnatal Depression Scale (EPDS). Texto adaptado del *British Journal of Psychiatry,* Junio, 1987, vol. 150 por J.L. Cox, J.M. Holden, R. Segovsky.

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptom. Items 3, 5-10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Users may reproduce the scale without further permission providing they respect copyright (which remains with the *British Journal of Psychiatry*) quoting the names of the authors, the title and the source of the paper in all reproduced copies.

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist primary care health professionals in detecting mothers suffering from postpartum depression (PPD); a distressing disorder more prolonged than the "blues" (which occur in the first week after delivery), but less severe than puerperal psychosis.

Previous studies have shown that PPD affects at least 10 percent of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long term effects on the family.

The EPDS was developed at health centers in Livingston and Edinburgh. It consists of 10 short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than five minutes.

The validation study showed that mothers who scored above a threshold 12/13 were likely to be suffering from a depressive illness of varying severity. Nevertheless, the EPDS score should not override clinical judgement. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother felt during the previous week, and in doubtful cases it may be usefully repeated after two weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

INSTRUCTIONS FOR USERS

1. The mother is asked to underline the response that comes closest to how she has felt during the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at six to eight weeks to screen postnatal women or during pregnancy. The child health clinic, postpartum check-up or a home visit may provide suitable opportunities for its completion.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

PUBLIC HEALTH PREPAREDNESS INDEX

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PUBLIC HEALTH PREPAREDNESS AND RESPONSE

DATE DEVELOPED: 5/12
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22

I. POLICY:

The Division of Public Health Services shall utilize funding received from the North Carolina Division of Public Health, Public Health Preparedness & Response (PHP&R) Branch per current agreement addendum guidelines to upgrade and integrate its public health preparedness and response plans for public health emergencies. The Division of Public Health Services shall work with federal, state, and local governments, the private sector, and non-governmental organizations to develop and maintain a preparedness and response program for Rockingham County.

II. PURPOSE:

The purpose of emergency preparedness and response planning efforts are to support the National Response Framework (NRF) and the National Incident Management System (NIMS). Funding will be used to enhance all hazards planning and direction, coordination and assessment, surveillance and detection capacities, risk communication and health information dissemination, telecommunications capabilities, and education and training.

III. GUIDELINES:

A. Activity # 514 funds shall be used to support the work and or function of the Division of Public Health Services' Preparedness Coordinator to accomplish, at a minimum, the activities listed below for the current agreement addendum period.

1. The local health department shall designate, at minimum, one representative as a Public Health Preparedness Coordinator to act as a point of contact with the PHP&R Branch and to perform the duties and functions as the Preparedness Coordinator. This person shall participate in state and regional planning processes by attending, at minimum:

a. 75% of the PHP&R regional planning meetings scheduled in the PHP&R region. To receive credit for attendance at each regional planning meeting, the Preparedness Coordinator must be present for a minimum of 75% of the time allotted for the meeting. Trainings and other applicable meetings can

count toward this requirement if approved by the Program Manager of PHP&R in advance.

b. The annual PHP&R Preparedness Symposium.

2. The Health Director and Preparedness Coordinator shall possess a functional Government Emergency Telecommunications Services (GETS) Card issued through PHP&R and return the GETS Card when no longer employed as Health Director or Preparedness Coordinator.

3. The Division of Public Health Services shall meet the following Public Health Preparedness (PHEP) requirements:

   a. Complete quarterly call down drills, Government Emergency Telecommunications Services (GETS) Card checks, redundant communication platforms and systems checks within the geographical boundaries of Rockingham County.
   b. Complete Training and Exercise Planning Workshop (TEPW) and Multi-Year Training and Exercise Plan (MYTEP) per Homeland Security Exercise Evaluation Plan (HSEEP) guidance.
   c. Complete trainings and exercises with After Action Reports (AARs) and Corrective Action Plans (CAPs) per Homeland Security Exercise Evaluation Plan (HSEEP) guidance.
   d. Complete an annual Public Health Emergency Preparedness Operational Readiness Review (PHEP-OOR) self-assessment and submit all required forms and evidence to the North Carolina Disease Event Tracking and Epidemiological Collection Tool (NC DETECT) database and in the CDC's Secure Access Management Service (SAMS) database prescribed by PHP&R no later than May 1, 2023.
   e. Provide updates and data for each Point of Dispensing (POD) and Local Receiving Site (LRS) locations, hospital information sheets, and other documents as requested.
   f. Complete and submit an annual Medical Countermeasure (MCM) Action Plan by May 31, 2023 and provide updates quarterly to the regional PHP&R Pharmacist.
   g. Update jurisdictional points of contact twice during each service period (December 31 and May 31), or as changes occur, on the Critical Contact tab within NC DETECT database to facilitate time- sensitive, accurate information sharing within the jurisdiction and between CDC and the jurisdiction.

4. The health department shall maintain preparedness and response activities by:

a. Maintaining a system to receive reports of communicable diseases or other public health threats on a 24-hour-a-day, 7 days a week basis.
b. Establish and maintain an OSHA compliant respiratory protection program in accordance with 29 CFR 1910.134.
c. Maintain a current Incident Command System (ICS) and National Incident Management System (NIMS) as guided by the North Carolina Public Health Workforce ICS and NIMS Training Directive.
d. Maintain radio equipment, as assigned, to communicate with local, regional, and state emergency communication networks.
e. Maintain public information staff to include at a minimum a Public Information Officer (PIO) and back-up PIO, that have been trained based on the *North Carolina Public Health Public Information Training Guide* directive.
f. Maintain the All-Hazards Base Plan, High Consequence Pathogens/Ebola Plan, Crisis Emergency Risk Communications Plan, and Pandemic Influenza Plan by May 31, 2023, and upload into the NC DETECT database.

5. Ensure considerations for at-risk individuals with access and functional needs, as defined in the most current edition of the *Hospital Preparedness Program - Public Health Emergency Preparedness (HPP-PHEP) Cooperative Agreement Guidance for At-Risk Populations*, are integrated in all planning, exercise and real-world responses.

B. Performance Measures/Reporting Requirements:

1. The Division of Public Health Services shall provide data as required by PHEP-OOR self-assessment and submit all required forms and evidence to the North Carolina Disease Event Tracking and Epidemiological Collection Tool (NC DETECT) database no later than May 1, 2023.

2. The Division of Public Health Services shall submit the following updates and reports into NC DETECT:

a. Homeland Security Exercise and Evaluation Plan (HSEEP) documentation and After Action Reports (AARs) within 120 days of conclusion of an exercise or real-world event/ incident and other documents as required by the CDC.
b. After Action Reports (AARs) within 120 days of the conclusion of an exercise or real-world event/incident.
c. Respiratory Protection Plan in accordance with 29 Code of Federal Regulations Part 1910.134 by May 31, 2023.

3. Submit Monthly Expenditure Monitoring Reports (EMRs) no later than 30 days after the month ends to the PHR&R Subrecipient Grants Monitor.

4. Provide all plans and documents for review by PHP&R staff, when requested. Plans and other documents shall be consistent with state and federal requirements and specific to Rockingham County.

5. Complete the following reports via the Smartsheet dashboard which can be accessed at https://app.smartsheet.com/b/publish?EQBCT=82018408e7b44ef9b44e113b6e536ffb.
All of the due dates for these reports are posted on the Smartsheet dashboard.

   a. Monthly Financial Reports: These monthly financial reports (formerly known as the Expenditure Monitoring Reports or EMRs) will report on the prior month. The first financial report is for June 2022 and is due by July 22, 2022.
   b. FY23 COVID-19 Response Plan Update Form: As an update to the information the LHD provided for FY22, this Response Plan Update Form is to provide information related to the LHD's COVID-19 preparedness and response. The Plan Update Form will present a series of questions to be answered in a short-answer format on topics including testing, contact tracing, vaccination, equity, and preparedness. Submission of a single COVID-19 Response Plan Update will meet the reporting requirements described under this Agreement Addendum as well as for other COVID-related Activities. The LHD's COVID-19 Response Plan Update will receive DPH oversight from the DPH Program Contact for each relevant COVID-related Activity. Specific questions regarding individual topics in the Plan Update Form should be directed to those individuals. Any general questions the LHD has should be directed to the DPH Division Director's Office at lhdhealthserviceta@dhhs.nc.gov. DPH will add the FY23 COVID-19 Response Plan Update Form to the Smartsheet dashboard by July 1, 2022. The LHD shall provide its responses no later than August 1, 2022.

C. Performance Monitoring and Quality Assurance:

1. PHP&R will provide technical support to the Division of Public Health Services in preparedness planning, training, and exercising. Templates, best practices, and conferences will be provided on an ongoing basis.

2. PHP&R staff will maintain open communication with the Division of Public Health Services and will receive and respond to all questions related to preparedness and response, SNS, exercises, telecommunication, and communication.

3. PHP&R's Subrecipient Grants Monitor or PHP&R Program Manager's designee shall schedule and conduct on-site visits with the Division of Public Health Services to assess compliance with the Centers for Disease Control (CDC) grant and Agreement Addendum requirements, financials, and/or provide consultative assistance.

4. Inadequate performance on the part of the Local Health Department directly impacts the capacity of North Carolina's ability in overall preparedness.

    a. In the event that performance is deemed inadequate or non-compliant, PHP &R reserves the right to identify the county as "high risk", which may result in a reduction or suspension of funds.
    b. While not necessarily an indicator of inadequate performance, inability to spend allocated funds will result in an assessment and potential recall of funds for re-allocation to other health departments.

D. Funding Guidelines or Restrictions:

1. Requirements for pass-through entities: In compliance with *2 CFR § 200.331 – Requirements for pass-through entities*, the Division provides Federal Award Reporting Supplements to the Local Health Department receiving federally funded Agreement Addenda (AA).

    a. Definition: A Supplement discloses the required elements of a single federal award. Supplements address elements of federal funding sources only; state funding elements will not be included in the Supplement. Agreement Addenda (AAs) funded by more than one federal award will receive a disclosure Supplement for each federal award.
    b. Frequency: Supplements will be generated as the Division receives information for federal grants. Supplements will be issued to the Local Health Department throughout the state fiscal year. For federally funded AAs, Supplements will accompany the original AA. If AAs are revised and if the revision affects federal funds, the AA Revisions will include Supplements. Supplements can also be sent to the Local Health Department even if no change is needed to the AA. In those instances, the Supplements will be sent to provide newly received federal grant information for funds already allocated in the existing AA.

2. In order to fulfill the CDC Public Health Emergency Preparedness (PHEP) requirements of administrative and budget readiness, in the event that additional funds become available, revisions will be made to the budgetary estimates and unless otherwise stated, activities will be defined by the Public Health Performance Capabilities.

3. PHP&R will distribute funds to Local Health Departments through the Controller's Office based on standard DPH procedures.

    a. It is anticipated that the level of funding provided through the Agreement Addendum will not be sufficient to support all activities that the Division of Public Health Services will undertake and that other resources may be necessary to meet the requirements.
    b. Specific unallowable expenses can be found in the HPP-PHEP Cooperative Agreement and the Notice of Award to PHP&R.

4. PHP&R reserves the right to review any expenditure that is not in line with the purpose and scope of the funding source. After review of the expenditure PHP&R may reject the expenditure and then require the county to further justify or pay back the expense.

5. Equipment and supply purchases and contracts exceeding $2,500.00 for single or multiple item(s) must receive prior written approval from PHP&R.

6. None of the funds made available under this agreement may be used to promote or advocate the legalization or practice of prostitution or sex trafficking. Nothing in the preceding sentence shall be construed to preclude the provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and when proven effective, microbicides.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

QUALITY IMPROVEMENT POLICIES

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: MISSION STATEMENT

DATE DEVELOPED: 11/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/22; 6/24

I. POLICY:

The Division of Public Health Services strives to provide services to the citizens of Rockingham County based upon our agency established mission statement.

II. PURPOSE:

To identify the intended outcome of our services we deliver.

III. GUIDELINES:

A. **All staff will be instructed of the agency's mission statement during orientation for the newly hired employee**.

B. After the consolidation of the Rockingham County Department of Social Services and the Rockingham County Department of Public Health a new mission statement was drafted.

C. The Governing Board will review and discuss the mission statement to assess its effectiveness to the citizens that we serve.

D. The mission statement as presented to the Rockingham County Board of Health and Human Services on June 7, 2022 is as follows: Rockingham County Department of Health and Human Services in collaboration with our community will provide quality services to promote the health, safety, and wellbeing of everyone through education, care, and advocacy.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

COMPLIANCE CHECKLIST

COMPLIANCE WITH FEDERAL, STATE AND LOCAL LAWS

The following list contains essential documents commonly needed to meet accrediting bodies: standards relating to compliance.

Compliance Program	
Policies Related to Compliance: ☐ Medicaid ☐ State Laws ☐ Personnel Management ☐ Safety ☐ Discrimination ☐ Sexual Harassment ☐ Reporting Violations ☐ Disciplinary Action ☐ Monitoring and Auditing ☐ Education ☐ Clients with Limited English Proficiency ☐ Sensory-Impaired Persons ☐ Compliance Officer Identified ☐ Compliance Orientation Check Sheets for All New Hires and Every Employee Annually ☐ Annual Compliance Reports	Notices Posted for: ☐ Compliance/Printed Rights 9/04 ☐ Minimum Wage ☐ Nondiscrimination ☐ Family Medical Leave Act ☐ Labor Laws ☐ Civil Rights Act/EEOC ☐ Blood Borne Pathogens ☐ Other OSHA, ADA, Labor-Related These notices are displayed in the following locations. a. employee entrance first floor b. first floor bulletin board outside – copyroom c. first floor - environmental health d. second floor - dental office e. second floor – middle breeze way ☐ Suggestion Box Available

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: QUALITY IMPROVEMENT/QUALITY ASSURANCE

DATE DEVELOPED: 4/14
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/20; 6/22; 6/24

I. POLICY:

The **Rockingham County Division of Public Health** (**RCDPH**) endeavors to achieve optimal client service outcomes that are consistent with the mission and values of the organization, by utilizing available resources through the development, implementation and evaluation of an effective Quality Improvement Council (QIC). **RCDPH** shall utilize an ongoing, planned, systematic and objective performance assessment and quality improvement plans in order to continuously strive to improve the quality of care and services to the agency's clients and meet the needs and expectation of its internal and external customers.

II. PURPOSE:

The purpose of the QIC is to provide a forum for representation from all areas of the **RCDPH** to initiate, implement, and support quality improvement within our agency. The Council will help set QI/QA priorities and make recommendations to the Leadership Team regarding QI/QA projects. The QIC will promote quality improvement programs and support recognition of team accomplishments. Its members are responsible for helping create a quality improvement culture in which employees will use quality improvement principles and techniques in their day-to-day work. Quality assurance is ensured by ongoing evaluation and assessment of client expectations of services and consumer input through the QIC evaluation and collaboration to implement improvement processes.

III. GUIDELINES:

A. Goal - The QIC is chartered by the Leadership Team (administrative staff) to prioritize and subsequently direct the implementation of agency-wide strategic quality improvement projects. This will be accomplished by assessing agency-wide needs, feedback from our consumers, and by working in conjunction with agency directors to achieve goals set by the local county commissioners.

B. Methods and Procedures –

1. Composition: The QIC will be comprised of representatives from all areas of the **RCDPH** with at least two members from the

Leadership Team, one of which will be the member-at-large. The Health Director may serve as advisor. Initially, the chairperson will be selected by the Health Director.

2. Member Responsibilities: QI/QA members are expected to attend and participate in council meetings. Members will be responsible for communicating with their co-workers to update them on QI/QA projects and to elicit ideas for improvement from other staff members. Meeting minutes will be documented by one of the council members.

3. Meetings and Process: Meetings will be held quarterly but work groups may meet more frequently, if needed.

4. Relationships: The QIC member who is the Leadership Team member-at-large will be the liaison to the Leadership Team. The Leadership Team will make the final decision on the QI/QA projects that will be undertaken.

5. Decision Making: Decisions will be made by majority vote and will be based on available data.

6. Scope and Boundaries: The QIC will oversee agency-wide projects that have strategic significance and in select cases, those with programmatic importance. All QI/QA projects conducted within the RCDHHS, including but not limited to agency satisfaction surveys, will be documented and presented to the QIC to increase awareness and benefit from lessons learned.

7. Quality Improvement activities are organized to plan, design, measure and assess **RCDPH** performance with the ultimate goal of improving the quality of client services. The Plan, Do, Study, Act Cycle of Improvement will be utilized. All staff will be aware that this is an opportunity for everyone to identify issues regarding DHHS services that are positive as well as those that need improvement.

   The PDSA Cycle is used for Quality Improvement activities and should answer a set of fundamental questions that form the basis of improvement:

   a. What are we trying to accomplish?
   b. How will we know that a change is an improvement?
   c. What changes can we make that will result in improvement?
   d. Plan how to implement the intervention or change.
   e. Do it (carry out the change, preferable on a small scale).
   f. Study the process to see whether the intervention or change made an improvement.
   g. Act on what was learned.

8. Surveys:

Client/Consumer

a. Client Satisfaction Surveys are distributed to all programs monthly.
b. Attempts will be made to seek every client's participation in completing the survey.
c. Electronic surveys through EHR system will be compiled and results will be emailed among staff monthly.
d. The results will be compiled quarterly and a report of the findings will be generated among staff. Areas for improvement will be addressed by the Quality Improvement Team.

Community

a. At community events, the public will be surveyed for awareness of services, hours of operation and suggestions for service improvement.
b. This survey will be online through the Public Health website **or through paper surveys** and randomly distributed by staff throughout the community. **Public events are another avenue for community input.**
c. The results will be compiled annually and a report of the findings will be generated among relevant staff. Areas for improvement will be addressed by the Quality Improvement Team and/or Administrative Team.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMPLIANCE NOTICE

DATE DEVELOPED: 2/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

All employees of the Division of Public Health Services must conduct business in compliance with all applicable federal, state and local laws and regulations as well as with the Division of Public Health Services' code of ethics and policies and procedures at all times.

II. PURPOSE:

It is the intent of the Division of Public Health Services to comply totally with all the legal and regulatory requirements under which the agency must operate.

III. GUIDELINES:

A. In order to maintain the highest standards of ethical conduct and fair dealing, each staff member, supervisor, and director will have primary responsibility for ensuring that the employees he/she supervises conduct themselves in compliance with the agency's standards.

B. Each employee is to receive, and be in-serviced with, a copy of the Department's compliance program.

C. Each employee is expected to report any activity or action that he/she believes to be or might be a violation of the laws or regulations under which the Division of Public Health Services operates to their supervisor and/or any member of the Administrative Team.

D. The Administrative Team may recommend appropriate action for violations that come to its attention.

E. If an internal investigation reveals a potential violation that could result in exposure for overpayments or civil money penalties, an investigation may be conducted by an outside party.

F. No retaliation of any kind will ever be taken against an employee who reports an actual or suspected violation of laws, regulations or policies.

G. Compliance information will be included in the in-service programs or during unit meeting as needed in an ongoing effort to educate employees concerning the laws and regulations they must abide by.

H. The Division of Public Health Services organizes, manages and administers its resources to attain and maintain the highest practicable functional capacity for each client regarding medical, nursing, nutritional, or environmental health, as indicated by the need of services.

I. When a client seeks services the Division of Public Health Services assumes responsibility for the interdisciplinary coordination and provision of services ordered for the client.

J. The Division of Public Health Services assures that the majority of total professional services are routinely provided directly by the staff. Contractual agreements may be implemented. The written agreement may address: the nature, scope and type of care and service to be provided; the role, if any, of the contracted individual or provider in servicing clients, assessing clients, including who is responsible for initial and ongoing assessments, identifying the individual responsible for the service planning process, coordinating, supervising and evaluating the care and services provided, scheduling visits or hours, the required documentation and the time frame for completing and submitting such documentation, the responsibility of the contracted individual or provider to comply with applicable organization policies and provider qualifications; the procedures for determining charges and reimbursement; and the term for the agreement and conditions for renewal or termination.

K. The clinical services provided by the Division of Public Health Services are provided under the supervision of supervising physicians through contractual agreements and standing orders that have been approved.

L. Client services are appropriately integrated throughout the organization.

If you have any questions about this policy, please contact the Staff Development Coordinator or the Director of Nursing.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMPLIANCE PROGRAM

DATE DEVELOPED: 2/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/24

I. POLICY:

The Division of Public Health Services complies with all applicable local, state, and federal laws and regulations. At no time will any employee of the Division of Public Health Services be asked or obligated to do anything on behalf of the agency that he/she reasonable believes is illegal, unethical or in conflict with agency policy or applicable legal or regulatory requirements. Any employee who has questions about the ethics, propriety or legality of any policy or action regarding services is encouraged to raise the question with his/her supervisor and may, at any time, raise the questions or concern with any member of the Administrative Team.

II. PURPOSE:

A. To identify that all employees of the Division of Public Health Services must conduct business in compliance with all applicable federal, state and local laws and regulations at all times.

B. To establish guidance on laws and regulations that are set forth for all programs and services.

C. To implement Medicare, Medicaid, Department of Health and Human Services, personnel management, safety, discrimination, employment laws/regulations and other governing regulations, and programmatic local and state guidelines into the Division of Public Health Services' policies of practice.

III. GUIDELINES:

A. Employee Rights and Responsibilities:

Each Division of Public Health Services director and supervisor is responsible for:

1. Making sure the employees under his/her supervision understand and comply with the laws, regulations and policies and procedures of the Department;

2. Creating and maintaining a work environment in which compliance is expected and encouraged;

3. Responding to questions and concerns regarding compliance and elevating such questions and concerns to the Administrative Team whenever the manager or supervisor has doubts about the appropriate course of conduct; and

4. Detecting and correcting any lapses in compliance law, regulations or policy, and reporting such lapses to the Administrative Team for such remedial or disciplinary action as may be appropriate

Each Division of Public Health Services' employee is responsible for:

1. Knowing and complying with the legal requirements and the agency's policies and procedures governing his/her job responsibilities;

2. Raising with his/her supervisor and/or Administrative Team any questions or concerns the employee may have regarding the propriety or legality of any action that seems to conflict with applicable law, regulation or agency policy;

3. Informing his/her supervisor of any violations of law, regulation, or agency policy or procedure of which the employee becomes aware; and

4. Cooperating in any agency investigation of alleged violations of law, regulation or agency policy.

Abiding by these standards is everyone's duty and is therefore a condition of continued employment.

B. Medicare, Medicaid and the State DHHS services are provided at the Division of Public Health Services.

1. Clinical services are provided under the plan of care/standing order, and documented in the client's clinical record and will be billed to the Medicare or Medicaid program, if applicable.

2. It is a crime for anyone to offer, pay, solicit or receive anything of value to induce another person to refer a client for services or to get another person to buy or lease any kind of item, good or services for which Medicare, Medicaid or other federally-funded programs may pay. Physicians, health care providers may refer clients to the agency for services, and the agency must be scrupulous to avoid any appearance that it is offering or providing anything of value in order to receive referrals. (Reference Article V Section 3 – Gifts and Favors of Rockingham County Personnel Policy p. 14.)

3. Reimbursement may be provided to the agency on the basis of the costs it incurs in providing some services. To obtain reimbursement for its services the agency files an annual cost report. Timesheets, expense vouchers and mileage reports are all documents used to support the accounting records that in turn support the agency's cost of doing business. Employees must be scrupulously honest and careful in preparing all paperwork for the agency because that paperwork supports the agency's claims for reimbursement.

C. Medicaid and Medicare Certification

The Division of Public Health Services will comply with all requirements to maintain current certification as an agency.

D. NC Public Health Laws

E. Law Enforcement Requests

1. The Division of Public Health Services will cooperate, at all times and in every possible way, with law enforcement requests, as permitted by HIPAA, Confidentiality Laws and Rockingham County Policies.

2. The Division of Public Health Services will respond to subpoenaed requests for records.

   a. No record will be released without appropriate authorization or court order.
   b. If proper authorization cannot be determined, the Health Director may seek legal counsel prior to releasing any information or records.
   c. Consultation with the County Attorney's office is ongoing for all legal issues or issues in question.

3. The Health Director is to be notified immediately upon receipt of any subpoena.

4. The employee will notify his/her supervisor and the Health Director before taking any action if an attorney or other person contacts him/her concerning a legal matter, which might involve Rockingham County Department of Public Health, either directly or indirectly, either in the form of a subpoena.

F. NC Practice Acts

1. The Division of Public Health Services provides services in accordance with recognized standards of professional practice as

defined by each disciplines practice acts and with all applicable regulations controlling the practice of the disciplines providing the services.

2. The Division of Public Health Services shall function in accordance with state and federal laws. Duties assigned to staff will be in compliance with limitations imposed by the discipline specific practice acts.

3. The Division of Public Health Services will maintain contact with the applicable state boards regulating the services provided by Rockingham County Department of Public Health to clarify the contents of the practice acts as they relate to the services provided by the Division of Public Health Services.

4. Copies of applicable occupational practice acts will be readily available to the Division of Public Health Services.

G. Personnel Management:

The Division of Public Health Services will hire only qualified, competent individuals who meet specific job requirements and will follow policies described in the Administrative Policy Manual when hiring employees. The Division of Public Health Services takes screening precautions to ensure that employees meet applicable licensing and certification requirements and are eligible to participate in the delivery of services. New hires are offered employment under a conditional hire until results of urine screen checks are obtained.

1. Affirmative Action/Equal Employment

   a. The Division of Public Health Services is an affirmative action/equal opportunity employer. Therefore, it is the policy of this agency to afford equal opportunity to all qualified employees and applicants for employment regardless of race, sex, age, color, creed, religion, national origin, political affiliation or physical handicap.
   b. Employees and applicants for employment will be afforded equal treatment with respect to all terms, conditions and privileges of employment, including recruitment, selection, placement and opportunities for advancement.
   c. This policy applies to all position levels.
   d. Employee personnel files are completed and maintained according to state and federal laws, guidelines, accreditation standards and/or agency policy. Confidentiality of personnel files is maintained. Employees receive an orientation pertinent to their job duties as well as ongoing in-service education. Competency testing for staff is maintained.

Evaluations/performance appraisals are administered according to policy following the employee's probationary period, annually, and whenever deemed necessary by a supervisor.

All new employees will undergo compliance training in the agency's standards of conduct as part of their orientation, and will undergo annual compliance refresher in-services. In addition, employees will be informed that part of their performance evaluation will be based on their adherence to agency policies and procedures and that failure to adhere to the standards of conduct or agency policies and procedures, including the failure to report violations of which the employee is aware, will result in appropriate discipline and including termination.

2. Fair Labor Standards Act

   a. The Division of Public Health Services uses a standard 2080 work hours per year unless it is leap year, in which case the standard is 2088.
   b. The workweek goes from Saturday to the following Friday.
   c. The Agency adheres to the Federal Fair Labor Standards Act with regard to pay, hours of work and overtime pay.
   d. All hourly staff are nonexempt and, as such, are paid overtime for all hours worked in excess of 40 hours per week. Compensatory time may be granted instead of overtime pay.
   e. Professional staff are exempt and are paid to work a 40-hour week. Exempt staff are not compensated for overtime. However clinical positions may require greater than a 40-hour work week and leave is adjusted to compensate, per supervisor's discretion.
   f. All overtime hours require prior approval by the immediate supervisor.
   g. Overtime is paid at time and one half the employee's usual pay rate, provided the employee has accrued a 40-hour work week. Compensatory time may be granted instead of overtime pay.

3. Americans With Disability Act

   a. In accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, the Agency shall provide reasonable accommodation to the known physical or mental limitations of qualified handicapped employment applicants or employees, unless the

accommodation would provide an undue hardship on the operation of the Agency.

b. A qualified handicapped applicant or employee is a person who, with the provision of reasonable accommodation, can perform his/her essential job functions.

c. The need for reasonable accommodation and undue hardship will be determined on a case-by-case basis, according to the handicap of the employee.

4. Discrimination

The Division of Public Health Services considers applicants for employment and makes employment decisions regarding promotion, termination and working conditions solely on the basis of individual's qualifications and without regard to race, color, creed, religion, sex, national origin, age, political affiliation, physical handicap**, marital status, gender identification, or number of pregnancies**.

5. Sexual Harassment

The Division of Public Health Services will not tolerate the sexual harassment of any employee or client or by any employee of the agency regardless of his/her position, per agency policy.

H. Safety and OSHA:

1. Safety

The Division of Public Health Services is committed to providing a safe working environment. Directors and supervisors are expected to provide adequate in-service training in the use of potentially hazardous supplies or equipment, as well as in procedures used in the office or in the client's home. Attending to safe work process/procedures and refraining from engaging in unsafe acts are all employees' responsibilities. No employee should jeopardize his/her own or another's safety regardless of the circumstance.

The Division of Public Health Services' policies with respect to the use of illegal drugs and alcohol are a critical safety factor for employees and the client's they serve. Use of illegal drugs and alcohol violates agency policy and will not be tolerated. Rockingham County Department of Public Health will follow the policies as outlined in the Rockingham County Personnel Policy Manual.

2. OSHA Standards

   a. The Division of Public Health Services will comply with all OSHA requirements to ensure a safe workplace.
   b. The Division of Public Health Services has developed and implemented appropriate education and training for all staff, health screening and vaccination and an Exposure Control Plan, which addresses all aspects of the OSHA Bloodborne pathogen, and Tuberculosis Standards.
   c. The Division of Public Health Services maintains Material Safety Data Sheets for all products used by Agency staff.

I. Reporting Violations

The Division of Public Health Services is aware that most violations of law, regulations or agency policies and procedures occur unintentionally or by accident. However, we are committed to reducing the possibility that such violations will ever occur by providing a thorough orientation and training program, and by instructing employees in preventing any such violations. The Division of Public Health Services is committed to detecting and correcting such violations swiftly if they do occur. Normal operating and auditing procedures should bring them to light and lead to their correction. The Division of Public Health Services will engage in a regular program of self-auditing and monitoring to detect any material weaknesses in its policies and procedures and will take steps to strengthen areas of potential vulnerability whenever they are found. Employees do assist in this process. Employees are encouraged to identify areas within the Department's existing policies and procedures that could lead to violations.

They may do so by contacting their supervisors, by placing a suggestion in the digital suggestion box that is provided online **(this can be anonymous or identifiable per submitter)**, or by offering their suggestions to the Administrative Team or the Staff Development Coordinator.

If employees have any doubts about the legality or propriety of any course of action, they should consult the policies and procedures of the agency, ask their immediate supervisor, or raise the question with a member of the Administrative Team or with the Staff Development Coordinator. Employees are encouraged to raise questions or concerns before the activity takes place so that the employee can be certain that he or she is acting in accordance with the law and/or policy.

Each employee is expected to report any activity or action that the employee believes is or might be a violation of law, regulation or agency policy, whether it is accidental or intentional. A violation should be reported to an employee's immediate supervisor. If such a report is ignored, if the employee believes that the supervisor may be involved in the violation, or if

the employee continues to have concerns after bringing the matter to the supervisor's attention, the employee should report the situation to the next level of authority.

The Health Director or Administrative Team will promptly investigate the matter and, if appropriate, ensure that prompt corrective action is taken.

It is helpful for the Administrative Team to communicate directly with the person reporting a suspected violation. Reports may be made anonymously, but employees should recognize that an anonymous report might make it more difficult to investigate and successfully resolve the reported violation. To the extent practical, the Health Director and Administrative Team will not disclose the identity of the employee making the report. In no event will an employee be subject to retaliation or any form of adverse action for asking a question concerning the propriety of any action or for reporting a suspected violation as discussed in this policy.

Employees should not hesitate to talk to their supervisors about a question of business conduct no matter how small or insignificant it may seem. A single question may clarify a situation and avert a potential problem for the whole department. All managers should make themselves available to anyone with such questions and should take steps to publicize their answers to all affected employees within the agency. Questions may be referred to the Administrative Team if the supervisor is unable to answer them or if the answer is likely to have agency-wide significance. The Administrative Team will take steps to disseminate the answers to such questions through the agency.

J. Disciplinary Action

The directors and supervisors will take necessary steps to implement the disciplinary process to ensure compliance of the agency policies. The Administrative Team may recommend appropriate actions for violations presented.

K. Monitoring:

Many of the procedures of this compliance program are already in place, and the agency presumes that its employees are in compliance with these laws, regulations and policies. A compliance program requires the agency to monitor and audit its operations regularly. Thus, the agency has established a self-monitoring program with regular internal audits of its various operations to ensure compliance and to detect any weaknesses requiring corrective measures. Primary responsibility for implementing this program rests with the Administrative Team. These professional directors/supervisors shall make a good faith effort to be alert to violations of law, regulations and policy and shall recommend to the Administrative

Team any additional procedures that they may deem appropriate for monitoring/auditing compliance and preventing and detecting possible violations.

Managers shall be responsible for conducting a self-audit of the areas under their responsibility and for identifying areas of greatest risk for compliance failures.

L. Education

The laws and regulations for services are frequently changing. The Division of Public Health Services informs its staff as soon as changes are known and conducts in-service training to ensure that staff understand them.

New employees are in-serviced during orientation regarding laws, regulations, policies, and Corporate Compliance Program.

This Compliance Program is a brief overview of applicable law, regulations and policy. The Division of Public Health Services requires that all employees frequently review and follow the more specific agency policies and procedures.

M. The following topics are identified as a framework in which ethics and billing practices are established within the Division of Public Health Service's policies and procedures.

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Topic:

I. Objectives
II. Responsibility and Accountability
    A. Mission
    B. Goals
    C. Objectives
    D. Personal Conduct
    E. Contractual Terms & Conditions for contractors and vendors
III. Compliance of Notification of services for clients and families
    A. Duty of staff
    B. Process for handling questions and complaints from clients and family members
IV. Compliance Program Education
    A. Orientation programs for board members, management, supervisors, staff, vendors, contractors, students
    B. Competencies for orientation program
    C. In-service programs
V. Code of Ethics
VI. Accounting and Billing practices
    A. Description of Accounting
    B. Description of billing and coding
    C. Process for resolving questions or issues under billing, coding, and accounting practices
VII. Client Care Compliance issues
    A. Client Satisfaction
    B. Termination of care by client or family
    C. Termination of care by payer
    D. Termination of care by the Division of Public Health Services
VIII. Management Compliance Program requirements
    A. Duty to report compliance issues
    B. Responsibilities for monitoring, investigating and resolving compliance issues
    C. Performance evaluation related to corporate compliance responsibilities
    D. Termination for noncompliance
IX. Screening procedures
    A. Pre-employment drug screen
    B. Updating credentials
X. Financial integrity of the agency
    A. Insurance requirements
XI. Reporting procedures
    A. Process for internal reporting known or suspected

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMPLIANCE WITH FEDERAL, STATE AND LOCAL LAWS

DATE DEVELOPED: 2/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

A. The Rockingham County Board of Health and Human and Division staff strive to have the agency operate and furnish services in compliance with all applicable federal, state and local laws and regulations.

B. Local Health Departments are created through the N.C. General Statutes and provide services through a consolidated agreement with the State of N.C. There is no license from the State for the Division of Public Health Services. At the time of the Division of Public Health Services' initial request for certification, for each survey, and at the time of any change in ownership or management, the Board of Health and Human Services (BOHHS) will disclose the name and address of all persons with an ownership or control interest in the agency, the name and address of each person who is Health Director, Director of Nursing, supervisor or a managing employee of the Division of Public Health Services, the name and address of the agency, association or other company that is responsible for the management of the Division of Public Health Services, and the name and address of the Health Director and Chairperson of the BOHHS of that agency, association or other company responsible for the management of the Division of Public Health Services.

C. Whenever the membership of the BOHHS, the ownership or the administration of the Division of Public Health Services is changed, or the agency location is moved, the BOHHS assures that the appropriate regulatory bodies are notified in writing.

D. If the Division of Public Health Services chooses to refer specimens for laboratory testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with applicable federal and state requirements.

II. PURPOSE:

To assure that the Division of Public Health Services complies with all applicable federal, state and local laws and regulations.

III. GUIDELINES:

A. The Division of Public Health Services completes the application for state licensure and accreditation for the agency, initially and prior to the time of renewal. Accurate information and the appropriate fees if applicable are included with the application.

B. Each time there is a change in ownership or management, the Health Director or a designated person notifies, in writing, the state licensing and certifying body of the changes, giving the name and address of the current persons holding the positions.

C. The Division of Public Health Services completed the application for CLIA waiver initially and will complete prior to each renewal date. Accurate information and the appropriate fees are included with the application.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ORGANIZATIONAL/STRATEGIC PLANNING

DATE DEVELOPED: 2/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The administrative staff of the Division of Public Health Services will implement an organizational planning process for decision making within the agency.

II. PURPOSE:

To provide the framework for planning the services to be provided by the agency.

III. GUIDELINES:

A. Organizational planning will include at a minimum:

1. Development of a mission statement, philosophy, and objectives for the agency.
2. Development of strategic goals for a one to two year period.
3. Development of a yearly budget for agency.
4. Development of a process for determining customer satisfaction.

B. Management of the agency will review and update progress toward strategic goals on a regular basis through:

1. Management/Administrative Team meetings
2. Annual Program Evaluation
3. Quality improvement reports and summaries
4. Review of agency specific statistics to determine if needs are met
5. Review of budgetary compliance

C. The agency has developed or updated within the past 12 months an agency strategic plan that:

- includes a review and analysis of factors influencing the health department's ability to improve the community's health
- utilizes local health status data and information to set goals and objectives
- utilizes community input where applicable

- states desired outcomes for each element
- utilizes community collaborations to implement activities as appropriate
- set priorities

The management team meets annually as a retreat session to review previous year's strategic plan and identify existing issues or newly established issues.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ETHICAL ISSUES

DATE DEVELOPED: 2/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 623; 6/24
REVISED: 6/14; 6/22; 6/24

I. POLICY:

All services rendered by the Division of Public Health Services are provided in an ethical framework established by the professional, the agency and the law.

II. PURPOSE:

A. To define a mechanism for consideration and resolution of ethical issues that may arise with regard to services provided by the Division of Public Health Services.

B. To identify responsibilities of the Administrative Team, Staff and the Physician as related to the consideration of ethical issues.

III. GUIDELINES:

A. General

1. The Division of Public Health Services recognizes that issues of an ethical nature related to the client, agency and the provision of services may develop. Such issues may include, but are not limited to:

- Informed Consent
- High technology of services
- Accepting or refusing services
- Advance Directives in medical care if applicable
- Care of persons with inadequate reimbursement services
- Decision making
- Client safety
- Standards of services
- Confidentiality
- Right of Freedom of choice, dignity and movement
- Conflict about proposed services
- Appropriate behavior of staff in off site settings or acceptance of gifts from clients
- Any marketing procedures such as the Division of Public Health Services' pamphlet which describes the services provided

- The Division of Public Health Services' client admissions, transfers and discharges – the client is informed about the financial status of services during the registration of services and as changes occur throughout their services.

2. It is the policy of the Division of Public Health Services to:

   a. provide services within an ethical framework established by the professional disciplines provided by the agency, established in agency policy and procedure, and as established in the law.
   b. allow the client or his/her representative the right to participate as appropriate in discussions concerning ethical issues and to document such involvement.
   c. have any staff with direct involvement and the client's physician or physician extenders participate in the consideration and resolution of ethical issues.
   d. furnish staff with education regarding ethics and the mechanisms available to assist them with consideration and resolution of ethical issues.

3. The Division of Public Health Services' Administrative Team serves as a resource to assist in the consideration of ethical issues.

4. Minutes of all Administrative Team meetings will be completed and kept on file with the Administrative Assistant II or Health Director designee.

5. As appropriate, staff, the client, and the client's physician may be advised of the results of Administrative Team meeting regarding ethical issues in a manner appropriate to the individual situation.

B. <u>Administration Responsibilities</u>

1. Review and clearly define the organization's operations, the scope of services provided, criteria for eligibility, and education and training required of staff.

2. Educate the staff about the organization's policies on ethical issues; the organization's expectations of the staff; and the resources available to the staff to help evaluate ethical issues.

3. Routinely monitor cases to determine whether there is evidence of ethical questions or problems with the services being furnished; and whether staff are identifying them and responding appropriately.

4. Establish a mechanism for determining whether a client is competent to make appropriate decisions on his or her own behalf; including guidelines for seeking professional consultation with the client's physician, with a **mental health professional**, or with legal or protective services.

5. Establish a mechanism for determining whether the client's family members are making client services decisions in the best interest of and in keeping with the wishes of the client, and within the scope of their legal authority.

6. Implement policies for evaluating ethical issues or problems in a timely manner.

C. Staff Responsibilities

1. Keep informed about and understand the organization's policies and procedures for identifying, reporting, evaluating and resolving ethical questions.

2. Notify the administration about any situations that may pose a professional, moral or ethical issue.

3. Notify the administration about the outcome of any formal or informal action with respect to a potential ethical problem, including whether appropriate procedures were followed, the effectiveness of the intervention, and whether there is any recommendation for follow-up.

D. Responsibilities of Medical Director and Supervising Physicians for Client Care Services

1. Fully disclose to the Division of Public Health Services all information known about the client's condition and the client's wishes about care.

2. Make known and available to the Division of Public Health Services any advance directives or other documents executed by the client that record the client's wishes regarding his or her health care services.

3. Provide to the Division of Public Health Services any information necessary to ensure that the client has made an informed consent for the care ordered to be furnished by the Division of Public Health Services.

4. Be available as necessary to Division of Public Health Services to assist in evaluating ethical issues or questions that may arise in the course of the client's treatment or services.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLIENT CONCERNS/COMPLAINTS

DATE DEVELOPED: 3/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The Division of Public Health Services' staff members encourage clients to express their concerns about the agency's policies, care or services and recommend changes without fear of coercion, discrimination, reprisal, or unreasonable interruption of care or services.

II. PURPOSE:

To ensure quality services consistent with the Division of Public Health Services' mission and goals.

III. GUIDELINES:

A. Complaints regarding services of the department will be directed immediately to the Section Supervisor i.e., Clinic, WIC, Environmental Health, etc.

B. Complaints or concerns may be directed to the health department staff.

Staff members should:

a. Listen to concerns expressed by clients and resolve any immediate issues that can be addressed within the scope of their job functions.
b. Encourage clients to contact the office immediately to discuss any concerns or complaints that cannot be resolved with the Program Supervisor.
c. Relay information regarding expressed client concerns to the Department Supervisor.

C. The Department Supervisor or his/her designee will initiate an investigation for any complaint from clients, families, or other individuals in the community as soon as possible after becoming aware of the concern.

1. Complaints from clients may be documented on the "Client Complaint Form" by the individual receiving the complaint/concern and routed to the Supervisor/Director.

2. The Supervisor/Director or designee will review all client concern reports and initiate a problem-solving process within 24 hours if possible**,** to deal with the concern or complaint as follows:

    a. Inform the client that the client's concern has been received and is being reviewed.
    b. Inform the supervisor of the complaint and the supervisor will discuss with the staff member the exact nature of the concern.
    c. Identify the possible causes of the client concern.
    d. Plan and implement an appropriate corrective action, if applicable. If the client's concern relates to an individual's performance, actions are taken to assess the individual's competence.

        i. This concern is addressed as a potential area for performance improvement.
        ii. It is documented in the staff member's personnel record the steps taken to assess and improve the individual's performance.
        iii. Additional in-servicing or educational needs may be implemented.
        iv. If the performance does not improve, the Division of Public Health Services will seek appropriate action.
        v. If the client concern relates to an agency performance, the client's expectations and thought processes are reviewed. The Division of Public Health Services is consistently seeking ways in which to improve organizational performance. This may be performed through redesigning an existing process, or designing a new one and then evaluating the results. Priorities for redesigning or establishing new processes are set to potentially achieve an impact on performance, focusing on high-risk, high-volume or problem prone processes and doing so by utilizing available resources. Staff are expected to participate in these improvement strategies.
        vi. Evaluate the implemented corrective action plan to determine if the client's concern has been alleviated.
        vii. Inform the client of the corrective action taken to resolve the concern as permitted by the personnel policies.
        viii. Document the concern and the resolution of the complaint on the Client Complaint Form.
        ix. Settle matter quickly and mutually, if possible. If the employee acted within the Division of Public Health

Services' guidelines and according to Health Department and County Policy, inform client of the situation. Proceed to offer services within these guidelines if client chooses to receive them. Always thank the client for notifying us of their concern.

D. Problems identified as client care complaints/concerns may be referred to the Director of Nursing and/or Health Director.

E. The Director of Nursing periodically reviews documentation of client complaints/concerns and their resolution to determine if there are any patterns that indicate changes that the agency needs to make in policies or procedures to prevent future complaints/concerns.

F. In obtaining information, treat client or complainant with dignity. Do not make excuses or promises that cannot be kept. Never try to justify to the client before the investigation has been conducted.

G. Give your name and title when discussing the complaint with the complainant. The resolution may be made over the phone or through a home/office visit. Listen attentively to the client, remaining calm. Never argue with the client.

H. No employee should attempt to settle a client complaint in the event the client is unruly, loud, or verbally abusive. If the client continues to be unruly and loud, excuse yourself from the situation and seek assistance from supervision.

I. Remove the complainant from the clinical setting and discuss issues privately.

J. All complaints documented and followed up will be recorded and filed with the Staff Development Coordinator.

K. An annual report will be completed listing the complaint, findings and actions taken and presented to the Quality Improvement Council.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

CLIENT COMPLAINT

Date: _____ **Client Name:** _____

Complaint Made By: _____

Nature of Service: _____

Nature of Complaint/Recount of Event: _____

_____

_____

_____

_____

Employee Name: _____

Discussion of Event with Employee: _____

_____

_____

_____

_____

Plan of Corrective Action: _____

_____

_____

_____

_____

_____

_____

Complaint Received By: _____

Supervisor Notified & Date: _____

Staff Development Coordinator: _____

Evaluation of Correction Action: To determine if the client's concern has been alleviated:

Date _____

_____

_____

Reviewed By: _____

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CONFLICT OF INTEREST

DATE DEVELOPED: 2/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

It is the policy of the Division of Public Health Services to assure that no employee who has direct responsibility for negotiating and signing contracts, signing purchase requisitions/purchase orders, or approving the payment of money to contractors/vendors shall have financial interest in any such contract/vendor. Should the Directors, in the course of normal departmental operations, have a need for services or supplies from a contractor or vendor with such financial interest, then the following guidelines shall apply (see below). All members of the Board of Health and Human Services will promptly disclose any conflict of interest between his or her personal interests and the interest of the Division of Public Health Services. In order to avoid conflicts of interest or the appearance of impropriety, should instances arise where a conflict may be perceived, any individual who may benefit, directly or indirectly, from the Division's disbursement of funds, shall abstain from participating in any decisions or deliberation by the Division regarding the disbursement of funds. The Division recognizes the possibility that it may be the recipient of funds that are allocated consistent with the purpose and goals of its program. If such allocations are made, the Division will strive to ensure that funds are expended in such a manner that no individual will benefit, directly or indirectly, from the expenditure of such funds in a manner inconsistent with its program.

II. PURPOSE:

Agency leadership will establish guidelines, which circumvent opportunities for conflict of interest. To prevent individuals from deriving any profit or gain directly or indirectly by reason of their association with the Division of Public Health Services, without the prior knowledge and approval of the Governing Body.

III. GUIDELINES:

A. A purchase requisition with any related specifications, suggested vendors, detailed descriptions, etc., should be prepared by the staff/supervisors and forwarded to the Health Director.

B. The Health Director will be responsible for approving and signing that requisition. Input, if appropriate, should be solicited from the Health

Director. A determination should be made as to the appropriateness of the solicitation of bids from more than one vendor if the cost of teams/services warrants.

C. Following the approval of a purchase requisition and/or purchase order, any subsequent approvals of payment, contract amendments or any other commitments from obligations by the agency should also be directed to the Health Director.

D. All employees are expected to disclose to the Health Director, any transactions with third parties which would or could result in personal gain or profit or which are in competition with agency.

E. Failure to disclose such transactions may result in disciplinary action being taken.

F. The Division of Public Health Services' employees cannot be employed full time by another organization.

G. The work of the county will take precedence over other occupational interests of employees. All outside employment for salaries, wages, or commission, and all self-employment must be reported to the employee's Department Head who in turn will report potentially conflicting employment to the County Manager. Conflicting outside employment will be grounds for disciplinary action up to and including dismissal.

H. The billing processes for the Division of Public Health Services are completed as written in the agency billing policies. Under no circumstances are services rendered for individual non-work related financial gain purposes. Professional clinical staffing cannot provide individual discipline specific nursing services to a client that receives clinical services through the Division of Public Health Services. The client may not be able to differentiate the services of the agency or individual care services.

I. The DHHS Board conflicts of interest will be governed by state law.

J. The abstention and the reason shall be recorded in the minutes.

K. The Division of Public Health Services respects its staff members' cultural values, ethics and religious beliefs in delivering care to the client. If a staff member makes a specific request to <u>not</u> participate in client care due to the above reasons, the Division of Public Health Services may seek alternative methods to assign a different staff member so that the client's services are not interrupted.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: OBSERVING PUBLIC HEALTH AND RELATED LAWS AND REGULATIONS

DATE DEVELOPED: 3/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/22

I. POLICY:

The Division of Public Health Services will strive to ensure that the workforce consults and follows Federal, state, and local laws and regulations and the most current recommendations of regulating and advisory agencies in the delivery of essential and mandated public health services.

II. PURPOSE:

Provides usage and access information for the workforce on the laws, regulations and guidelines applicable to public health practices and services and related activities.

III. GUIDELINES:

Definitions:

1. CDC – Centers for Disease Control and Prevention – An agency of the United States government. The CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States. The Internet home page for the CDC is https://www.cdc.gov.

2. DHHS – North Carolina Department of Health and Human Services – A department of State government that is charged with "protecting health, fostering self-reliance and protecting the vulnerable." http://www.ncdhhs.gov. Essential public health services – "Essential public health services" means those services that the State shall ensure because they are essential to promoting and contributing to the highest level of health possible for the citizens of NC.

   Mandated public health services – The public health services that the State requires a local public health department to implement.

3. FR – Federal Register – The official daily publication for rules, proposed rules, and notices of Federal agencies and organizations, as well as executive orders and other presidential documents. The Internet search page for the CFR is located at http://www.federalregister.gov.

4. USCFR – United States Code of Federal Regulations – The codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is divided into 50 titles that represent broad areas subject to Federal regulation. Each volume of the CFR is updated once each calendar year and is issued on a quarterly basis. The Internet search page for the FR is located at www.ecfr.gov.

5. NCAC – North Carolina Administrative Code – A compilation of the administrative rules of approximately 26 state agencies and 50+ occupational licensing boards. Compilation and publication of the NCAC is mandated by G.S. 150B-21.18 NCAC is located on the web at http://ncrules.state.nc.us/ncac.asp.

6. NCGS – North Carolina General Statues – the laws of the state. Public health laws are located in the publication, Public Health and Related Laws of North Carolina, NCDHHS, Division of Public Health, 2002; and on the web at www.ncleg.net/.

   Ordinance – Ordinances are local rules adopted by the Board of County Commissioners. They cover animal control, subdivision, cable TV, noise, land use, manufactured homes, solid waste, erosion control and many other issues.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NONDISCRIMINATION

DATE DEVELOPED: 3/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14; 6/22

I. POLICY:

The Division of Public Health Services will not discriminate regarding clients that present for services nor applicants seeking employment.

II. PURPOSE:

A. To ensure consistency of services throughout the Division of Public Health Services.

B. To ensure that applicant choices for employment are based on the most qualified and are not viewed as discriminatory.

III. GUIDELINES:

A. Clients

1. The Division of Public Health Services provides services for those clients that meet the eligibility of the programs.
2. This information should be clearly defined within each program policy.
3. Clients are not denied services based on age, sex, race, color, religion, national origin, political affiliation, disability, gender identity, sex characteristics, number of pregnancies, or marital status.
4. Confidential services are available here.

B. Employees

1. According to the Rockingham County Personnel Policy, Article IV. Recruitment and Employment Section I.

   Statement of Equal Employment Opportunity Policy

   It is the policy of Rockingham County to foster, maintain, and promote equal employment opportunity. The county shall select employees on the basis of applicant's qualifications and without regard to age, sex, race, color, creed, religion, political affiliation or national origin except where specific age, sex, or physical

requirements constitute a bona fide occupational qualification necessary for job performance. Applicants with physical handicaps shall be given equal consideration with other applicants for positions in which their physical handicaps do not represent an unreasonable barrier to satisfactory performance of duties.

2. Implementation of EEO Policy

   All personnel responsible for recruitment and employment shall implement this personnel policy through procedures that will assure equal employment opportunity based on reasonable performance-related job requirements. Notices with regard to equal employment matters shall be posted in conspicuous places on county government premises in places where notices are customarily posted.

3. Please refer to the Rockingham County Personnel Policy for further guidance surrounding employment issues. The Division of Public Health Services follows the guidelines within the Rockingham County Personnel Policy.

C. Notices of the Fair Labor Standards Act can be located in the following areas:

1. First floor - bulletin board outside copy room

2. Second floor – copy room

3. Second floor – middle breezeway

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: TOBACCO FREE FACILITY

DATE DEVELOPED: 3/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The Division of Public Health Services adheres to a Tobacco Free Facility Policy.

II. PURPOSE:

To ensure health promotion and disease prevention, and to enforce the following Public Law.

III. GUIDELINES:

A. Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan or loan guarantee.

B. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment.

C. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per violation and/or the imposition of an administrative compliance order on the responsible entity.

D. By signing and submitting the application to the Consolidated Agreement under the Certification Regarding Environmental Tobacco Smoke, the Rockingham County Department of Public Health certifies that it will comply with the requirements of the Act. The Division of Public Health Services further agrees that it will require the language of the certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

E. The Division of Public Health Services prohibits the use of tobacco in all areas and grounds of the facility within fifty (50) feet of the facility.

F. The Division of Public Health Services has developed and posted notices within the facility to identify the facility as a "Tobacco Free Facility".

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: **TITLE VI OF THE CIVIL RIGHTS ACT OF 1964; POLICY ON THE PROHIBITION AGAINST NATIONAL ORIGIN DISCRIMINATION AS IT AFFECTS PERSONS WITH LIMITED ENGLISH PROFICIENCY**

DATE DEVELOPED: **3/03**
REVIEWED: **6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24**
REVISED: **6/23; 6/24**

AUTHORITY: Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq.

Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d *et. seq.* states: "No person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Regulations implementing Title VI provide in part at 45 C.F.R. Section 80.3 (b):

> "(1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, or color, or national origin:
>
> (i) Deny an individual any service, financial aid, or other benefit provided under the program:
>
> (ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others in the program;
>
> (2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program or the class of individuals to whom, or the situations in which such services, financial aid or other benefits, or facilities will be provided… *may not directly, or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination, because of their race, color or national origin, or have the effect of defeating or substantially impairing accomplishments of the objectives of the program with respect to individuals of a particular race, color, or national origin."*

I. PURPOSE:

The purpose of this Policy is to ensure compliance with Title VI of the Civil Rights Act of 1964, and other applicable federal and state laws and their implementing regulations with respect to persons with limited English proficiency (LEP). Title VI of the Civil Rights Act of 1964 prohibits discrimination based on the ground of race, color or national origin by any entity receiving federal financial assistance.

Administrative methods or procedures, which have the effect of subjecting individuals to discrimination or defeating the objectives of these regulations, are prohibited.

In order to avoid discrimination on the grounds of national origin, all programs or activities administered by the Division of Public Health Services must take adequate steps to ensure that their policies and procedures do not deny or have the effect of denying LEP individuals with equal access to benefits and services for which such persons qualify. This Policy defines the responsibilities the agency has to ensure LEP individuals can communicate effectively.

II. SCOPE OF POLICY

These requirements will apply to the Division of Public Health Services (herein referred to as "the agency") including subcontractors, vendors, and subrecipients.

The agency will ensure that LEP individuals are provided meaningful access to benefits and services provided through contractors or service providers receiving subgrants from the agency.

III. DEFINITIONS

A. Limited English Proficient (LEP) individual – Any prospective, potential, or actual recipient of benefits or services from the agency who cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies.

B. Vital Documents – These forms include, but are not limited to, applications, consent forms, letters containing important information regarding participation in a program; notices pertaining to the reduction, denial, or termination of services or benefits, the right to appeal such actions, or that require a response from beneficiary notices advising LEP persons of the availability of free language assistance, and other outreach materials.

C. Title VI Compliance Officer: The person or persons responsible for compliance with the Title VI LEP policies.

D. Substantial number of LEP: 5% or 1,000 people, whichever is smaller, are potential applicants or recipients of the agency and speak a primary language other than English and have limited English proficiency.

IV. PROVIDING NOTICE TO LEP INDIVIDUALS

The agency will take appropriate steps to inform all applicants, recipients, community organizations, and other interested persons, including those whose primary language is other than English, of the provisions of this policy. Such notification will also identify the name, office telephone number, and office address of the Title VI compliance officer(s).

The current name, office telephone number and office address of the Title VI compliance officers are listed below:

Amanda Jensen (Lead Title VI Compliance Officer)
Public Health Educator II
336-342-8149
Rockingham County Department of Health and Human Services
PO Box 204
Wentworth, NC 27375

Maria Buccini (Assistant Title VI Compliance Officer)
336-342-8194
336-342-8206 (Spanish voicemail)
Rockingham County Department of Health and Human Services
PO Box 204
Wentworth, NC 27375

(Note: the agency will notify the DHHS compliance attorney of changes in name or contact information for the Title VI compliance officer.)

A. The agency will post and maintain signs in regularly encountered languages other than English in waiting rooms, reception areas and other initial points of contact. These signs will inform applicants and beneficiaries of their right to free language assistance services and invite them to identify themselves as persons needing such services.

   Areas within the agency where these signs will be posted include:
   Waiting Rooms
   Appointment Desk
   Registration Desks

B. The agency will include statements of the right to free language assistance in Spanish and other significant languages in all outreach material that is routinely disseminated to the public (including electronic text).

C. The agency will also disseminate information in the following manner:

   Providing all agency brochures in Spanish (whenever possible).

V. PROVISION OF SERVICES TO LEP APPLICANTS/RECIPIENTS

A. Assessing Linguistic Needs of Potential Applicants and Recipients

1. The agency will assess the language needs of the population to be served, by identifying:

   a. the language needs of each LEP applicant/recipient
   b. the points of contact where language assistance is needed; and
   c. the resources needed to provide effective language assistance, including location, availability and arrangements necessary for timely use.

2. Determining the Language Needs of the Population to be Served

   The agency is responsible for assessing the needs of the population to be served. Such assessment will include, but not be limited to the following:

   a. The non-English languages that are likely to be encountered in its program will be identified.
   b. An estimate of the number of people in the community for whom English is not the primary language used for communication will be completed and updated annually. To identify the languages and number of LEP individuals local entities should review:
      i. census data
      ii. school system data
      iii. reports from federal, state, and local governments
      iv. community agencies' information, and
      v. data from client files

   c. The points of contact in the program or activity where language assistance is likely to be needed will be identified.

3. Determining the Language Needs of Each Applicant/Recipient

   The agency will determine the language needs of each applicant/recipient. Such assessment will include, but not be limited to the following:

   a. At the first point of contact, each applicant/recipient will be assessed to determine the individual's primary language. The following method will be used:
      - multi-language identification cards, a poster-size language list, or the use of "I speak" peel-off language identification cards for indicating preferred languages

b. If the LEP person does not speak or read any of these languages, the agency will use a telephone interpreting service to identify the client's primary language.

c. Staff will not solely rely on their own assessment of the applicant or recipient's English proficiency in determining the need for an interpreter. If an individual requests an interpreter, an interpreter will be provided free of charge. A declaration of the client will be used to establish the client's primary language.

d. When staff place or receive a telephone call and cannot determine what language the other person on the line is speaking, a telephone interpreting service will be utilized in making the determination.

e. If any applicant/recipient is assessed as LEP, they will be informed of interpreter availability and their right to have a language interpreter at no cost to them with a notice in writing in the languages identified in Section C. Provisions of Written Translations.

B. Provision of Bilingual/Interpretive Services

1. The agency will ensure that effective bilingual/interpretive services are provided to serve the needs of the non-English speaking population. The provision of bilingual/interpretive services will be prompt without undue delays. In most circumstances, this requires language services to be available during all operating hours.

   This requirement will be met by ensuring that there is a Spanish interpreter staff person and/or language line access available in the agency at all times. Currently, there are two positions classified as Foreign Language Interpreters (all Spanish Interpreters) and they are assigned to the Family Planning Section, and General Clinic. The Foreign Language Interpreter may be available to assist in other areas of the agency needing assistance.

2. The agency will provide language assistance at all level of interaction with LEP individuals, including telephone interactions.

3. The Division of Public Health Services may contract with an outside interpreter service.

4. The Division of Public Health Services may utilize services of community volunteers for interpretation.

5. Interpreter Standards

   a. Those providing bilingual/interpretive services will meet the linguistic and cultural competency standards set forth below.

The agency will ensure that interpreters and self-identified bilingual staff have first been screened to ensure that the following standards are met before being used for interpreter services:

i. Can fluently and effectively communicate in both English and the primary language of the LEP individual
ii. Can accurately and impartially interpret to and from such languages and English
iii. Has a basic knowledge of specialized terms and concepts used frequently in the provision of the agency's services
iv. Demonstrates cultural competency
v. Understands the obligation to maintain confidentiality
vi. Understands the roles of interpreters and the ethics associated with being an interpreter

During the interview process, our staff interpreter assesses competency of our applicants for speaking, reading and writing Spanish. Applicants are given scenarios to interpret, brochures to read in English and translate into Spanish, and brochures to read in Spanish.

Annually, competencies are assessed in the work setting using a competency skills checklist by peer review of another Spanish interpreter.

b. When staff members have reason to believe that an interpreter is not qualified or properly trained to serve as an interpreter, the staff member will request another interpreter and the supervisor will be notified.

6. Using Family Members or Friends as Interpreters

a. Applicants/recipients may provide their own interpreter; however the agency will not require them to do so.
b. The agency will first inform an LEP person, in the primary language of the LEP person, of the right to free interpreter services and the potential problems for ineffective communication. If the LEP person declines such services and requests the use of a family member or friend, the agency may utilize the family member or friend to interpret only if the use of such person would not compromise the effectiveness or services or violate the LEP person's confidentiality. The client will be asked to sign a Refusal to Interpreter Services form. The agency will monitor these interactions and again offer interpreter services, if it appears there are problems with this arrangement.

c. The agency will indicate in the LEP individual's file that an offer of interpreter services was made and rejected; that the individual was informed of potential problems associated with using friends or family members and the name of the person serving as an interpreter at the LEP individual's request. Any discharge instructions will be given to the client by agency interpreters.

d. The agency will keep a written record of when it has used a minor as an interpreter, and this information will be shared with the DHHS upon request. Minor children (under 18 years of age) should not be used as interpreters unless it is an emergency or extenuating circumstances where the client is needed right away and no one else is available.

7. The agency will not require the applicant/recipient to pay for bilingual/interpretive services

8. Use of Interpreters at Hearings

a. An interpreter will be provided for all hearings if a party requests an interpreter or if the Hearing Officer determines that an interpreter is necessary.

b. A separate oath or affirmation to translate accurately shall be administered to all interpreters.

C. Provision of Written Translations

1. The agency must provide written materials in languages other than English where a substantial number or percentage of the population eligible to be served or likely to be directly affected by the program needs services or information in a language other than English to communicate effectively.

2. Translation of Vital Documents

a. The agency will ensure that vital documents for locally designed programs are translated into Spanish. Written materials routinely provided in English must also be available in languages other than English that are regularly encountered through the Division of Public Health Services.

b. When state DHHS forms and other written material contain spaces in which the local entity is to insert information, this inserted information will also be in the individual's primary language. When such forms are completed by applicants/recipients in their primary language, the information must be accepted.

c. If, as a result of the local language assessment, it appears there are a substantial number of potential applicants or

recipients of the agency (defined as 5% or 1,000 people whichever is less) who are LEP and speak a language other than Spanish, the agency will translate and provide vital documents in the appropriate language. (DHHS counties should not translate DHHS forms. Please notify DHHS and DHHS will translate or verify county translation)

d. The agency will keep a record of all vital documents translated, and will submit this information to DHHS at their request.

3. If the primary language of an LEP applicant or recipient is a language other than Spanish AND the language does not meet the threshold for translation as defined in the preceding paragraph, the LEP individual will be informed in their own language of the right to oral translation of written notices. The notification will include, in the primary language of the applicant/recipient, the following language: IMPORTANT: IF YOU NEED HELP IN READING THIS, ASK THE AGENCY FOR AN INTERPRETER TO HELP. AN INTERPRETER IS AVAILABLE FREE OF CHARGE.

D. Documentation of Applicant/Recipient Case Records

1. The agency will maintain case record documentation in sufficient detail to permit a reviewer to determine the agency's compliance with this policy.

2. The agency will ensure that case record documentation, including computerized records if appropriate, identifies the applicant's/ recipient's ethnic origin and primary language. In those cases where the applicant/recipient is non-English speaking, the agency will:

a. Document the individual's acceptance or refusal of forms or other written materials offered in the individual's primary language.

b. Document the method used to provide bilingual services, e.g., assigned worker is bilingual, other bilingual employee acted as interpreter, volunteer interpreter was used, or client provided interpreter. When a minor is used as interpreter, the agency will document the circumstances requiring temporary use of a minor and will provide this information to NC DHHS upon request.

3. Consent for the release of information will be obtained from applicants/recipients when individuals other than agency employees are used as interpreters and the case record will be so documented.

E. Staff Development and Training

1. The agency will provide staff training at new employee orientation and at annual meetings. The training will include, but not be limited to:

   a. Language assistance policies and procedures, resources available to support such procedures, methods of effective use of interpreters, and familiarization with the discrimination complaint process.
   b. Cultural awareness information, including specific cultural characteristics of the groups served by the agency to provide a better understanding of, and sensitivity to, the various cultural groups to ensure equal delivery of services.

2. The agency will provide or ensure training is provided for bilingual staff and interpreters employed or utilized by the agency. This includes the ethics of interpreting, including confidentiality; methods of interpreting; orientation to the organization; specialized terminology used by the agency; and cultural competency.

3. The agency will ensure that applicable grantees, contractors, cooperative agreement recipients and other entities receiving state or federal dollars are trained in the requirements of this policy.

   Upon partnering or contracting with grantees, contractors, cooperative agreement recipients and other entities receiving state or federal dollars, the agency will provide this policy for them to review.

4. The agency will collect and maintain the following information about training provided to staff: the date(s) of such training, the content of such training, the number and types of credit hours awarded; and the names and identifying information of each attendee at the training. The agency will ensure that grantees, contractors, cooperative agreement recipients and other applicable funded entities collect and maintain such information as well.

VI. APPLICANT/RECIPIENT COMPLAINTS OF DISCRIMINATORY TREATMENT

A. Complaints

1. The agency will provide assistance to LEP individuals who do not speak or write in English if they indicate that they would like to file a complaint. A complaint will be filed in writing, containing the name and address of the person filing it or his/her designee and briefly describe the alleged violation of this policy.

2. The agency will maintain records of any complaints filed, the date of filing, actions taken and resolution.

3. The agency will notify the appropriate agency or Section within DHHS of complaints filed, the date of filing, actions taken and resolution. This information will be provided within 30 days of resolution.

B. Investigation

1. The Title VI compliance officer will conduct an investigation of the allegations of the complaint. The investigation will afford all interested persons and their representatives, if any, an opportunity to submit evidence relevant to the complaint.

2. The investigation will not exceed 30 days, absent a 15-day extension for extenuating circumstances.

C. Resolution of Matters

1. If the investigation indicates a failure to comply with the Act, the agency Director or his/her designee will so inform the recipient and the matter will be resolved by informal means whenever possible within 60 days.

2. If the matter cannot be resolved by informal means, then the individual will be informed of his or her right to appeal further to the Office of General Counsel within DHHS. This notice will be provided in the primary language of the individual with Limited English Proficiency.

3. If not resolved by DHHS, then complaint will be forwarded to OCR, USDHHS, Region IV.

VII. LEGAL ISSUES FOR COMMUNICATING WITH PEOPLE WHO HAVE LIMITED ENGLISH PROFICIENCY (LEP)

A. Criminal proceedings: Local health departments are responsible for enforcing communicable disease control measures. In carrying out that responsibility, they may issue isolation orders, and they may even prosecute someone for failing to comply with communicable disease control measures (in North Carolina, noncompliance with these measures is misdemeanor, punishable by a sentence of up to two years). Such prosecutions should not proceed if the individual being prosecuted has, because of a language barrier, failed to understand the control measures or the duty to comply with them.

B. Informed consent: A health care provider could be found liable for failing to obtain informed consent for treatment, if the client did not understand what the provider said about the treatment.

C. Other forms of malpractice: If a health care provider misunderstands the nature of the client's symptoms, the provider may misdiagnose a condition or treat it inappropriately.

D. The Division of Public Health Services will -

Monitor – annually:

1. Assess the current LEP makeup of the service area and the current communication needs of LEP clients.
2. Determine whether existing assistance is meeting needs.
3. Determine whether staff is knowledgeable about language assistance policies and procedures.
4. Determine whether sources of and arrangements for language assistance are still current and viable.

E. The LEP committee consists of the following staff members:

* Health Education Program Manager (chairperson)
* All in-house interpreters
* Staff Development Coordinator
* Dental staff representative
* Nursing staff representative
* Management support staff representative
* Administrative staff representative.

VII. FACILITY ACCESSIBILITY TO PERSONS WITH PHYSICAL DISABILITIES

A. The health department entrance is on level ground and has an automatic door.

B. An elevator is available for access to the second floor.

C. Braille signage is located throughout the facility.

D. Motorized exam beds are available to assist with transfer.

E. Bathrooms in registration area are handicap accessible.

F. Kiosk is wheelchair accessible.

G. Handicap parking spaces are available.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PUBLIC HEALTH DIRECTOR RESIDENCE REQUIREMENT

DATE DEVELOPED: 5/8/96
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/14

I. POLICY:

The Rockingham County Department of Health and Human Services Board requires the Public Health Director to reside in Rockingham County.

II. PURPOSE:

To ensure that the Public Health Director understands the request to reside in Rockingham County.

III. GUIDELINES:

Notwithstanding any other policy adopted by the Rockingham County Board of Commissioners relative to county employee activities, it is hereby required by the Rockingham County Department of Health and Human Services Board that the Public Health Director shall establish residence and live within the boundaries of Rockingham County within three months of employment.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

SAFETY GUIDELINES
INDEX

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: EMERGENCY EVACUATION GUIDELINES

DATE DEVELOPED: 3/05
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16

I. PURPOSE:

The Division of Public Health Services will establish an evacuation plan to ensure work site safety for its employees and clients. The county's Emergency Response Plan Guide will be followed.

II. SCOPE:

To identify a means of evacuation from the health department in the event of an unsafe surrounding which may be due to fire or some type of manmade or natural disaster.

III. AUTHORITY AND REFERENCES:

Rockingham County Board of Commissioners has assigned the responsibility, authority and accountability for safety to all department heads, supervising personnel and employees.

References:

- Rockingham County Government Employee's Safety and Health Handbook
- Rockingham County Government Emergency Response Plan Guide
- Rockingham County Fire Marshal

IV. GUIDELINES:

A. The Division of Public Health Services will work in collaboration with the Fire Marshal to establish a safe evacuation route.

B. The agency will ensure that the following safety measures are in place:

1. Adequate number of building exits.

2. Exits cannot be blocked from the inside so as to prevent free escape at any time.

3. Exits must be clearly marked and visible with no obstructions.

4. Lighting must be adequate to see exits.

5. Fire alarms must be in place and accessible.

6. No structure under construction or remodeling can be occupied if exits are unavailable/blocked.

7. All devices designed to assist emergency evacuation (fire doors, alarm systems, fire extinguishers, etc.) should remain continuously in proper operating condition.

IV. EMERGENCY PLAN REQUIREMENTS:

A. Escape procedures are as follows:

1. Top Floor – 2nd floor staff and clients should evacuate down the stairs closest to their location at the time of the alarm.

   There are 2 exits available:

   - The stairwell at the end of the hall outside the Family Care Coordination Room and the upstairs classroom.
   - The second is the stairwell located in the middle of the Governmental Center, which leads to the main governmental reception area.

2. Bottom Floor – 1st floor staff and clients should evacuate through the exit closest to their location at the time of the alarm.

   There are 3 exits available:

   - The stairwell at the end of the hall outside the clinic area leading to the outside parking lot. This is the employee entrance with keypad.
   - The second is the door leading out from the downstairs copy room – Pharmacy area and WIC.

     The staff and clients that exit this way still must exit the main building. If exiting to the right, the exit door is past the Governmental Center Reception area. If exiting to the left, exit through the glass hallway out through the back of the building at the docks.

   - The third is the main front entrance to the Health Department through the waiting area.

3. Staff are instructed to assist clients out of the building during evacuation.

4. Staff are expected to exit the facility as quickly as possible and take their personal belongings before evacuating.

5. Currently there are no staff identified as a critical operator – which means no staff should stay in the facility.

6. All staff are expected to relocate in one general area to account for staff. All Health Department staff will relocate in the northwest rear corner of the Health Department/Social Service parking area in front of the Economic Development Building.

   No matter which exit the employees and clients take, all are expected to gather at this location for a count.

7. Post evacuation will include all supervisors or department heads to account for their program staff.

   Supervisors or department heads should retrieve list of current staff before exiting the building.

   Once at the evacuation site – supervisors or department heads will re-count staff. Field staff are expected to sign out when leaving the building. Supervisors or department heads are expected to retrieve the sign out board to verify who was in the building and who was not.

8. Physician Extenders and clinical staff should immediately congregate after a counting of staff. Professional staff would assess the need for triage if injuries occur.

9. The clinical staff working within the triage room will remove the oxygen tank and emergency medical bag from the crash bag if possible. This can be used to provide medical services if needed.

10. The Health Department switchboard management support staff will announce the codes for an emergency situation.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: FIRE PREVENTION GUIDELINES

DATE DEVELOPED: 9/13/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16

I. PURPOSE:

To establish a fire prevention plan for the Division of Public Health Services and to ensure its guidelines are adhered to in order to provide safety measures for the staff.

II. SCOPE:

The Division of Public Health Services will implement the Fire Prevention Plan through instructions provided to its employees. The Rockingham County Employee Safety and Health Handbook along with the Rockingham County Government Emergency Response Plan will be followed.

III. REFERENCES AND AUTHORITIES:

The Rockingham County Board of Commissioners has assigned the responsibility, authority and accountability for safety to all department heads, supervising personnel and employees.

References:

- Rockingham County Government Employee Safety and Health Handbook
- Rockingham County Emergency Response Plan Guide
- Rockingham County Fire Marshal

IV. GUIDELINES:

TRAINING OF EMPLOYEES

A. Supervisors or designee shall inform their employees of fire hazards of materials and/or supplies to which they are exposed.

B. Upon initial assignment the supervisor or designee shall review with the employee those parts of the fire prevention plan which the employees must know in order to protect the employee in the event of an emergency. Such training shall be documented by the supervisor or designee.

C. The written fire prevention plan shall be maintained in the workplace and made available for employee review.

D. Employees are given these instructions during their orientation phase, annually, and/or as the need arises.

FIRE PLAN

A. In the event of a fire in the health department building:

1. Employees shall immediately remove all personnel and clients from the area and close the door.

2. Activate the fire alarm system.

3. Call 911.

4. Extinguish the fire if possible.

5. Get out of the building.

B. Employees and clients shall exit the building through the primary and secondary exit routes shown on the fire escape plan.

1. The primary exit travel routes should be utilized as the main escape route from the building.

2. Secondary exit travel routes are utilized when fire prevents exit by the primary route.

3. Employees and clients shall exit the building and walk to the northwest rear corner of the Health Department/Social Service parking area in front of the Economic Development Building.

4. Fire escape notification shall be through the audible and visible fire alarms.

C. Inspections

Inspections are a monthly “quick check” to insure that all extinguishers are available and will operate. It is intended to give reasonable assurance that the extinguishers are fully charged and operable. This is done by verifying that the extinguishers are in their designated places, that they have not been actuated or tampered with, and that there is no obvious physical damage or condition to prevent operation.

D. Procedures

Periodic inspections of extinguishers shall include a check of the following items:

1. Located in designated place.

2. No obstruction to access or visibility.

3. Operating instructions on nameplate legible and facing outward.

4. Seals and tamper indicator not broken or missing.

5. Determine fullness by weighing or “hefting”.

6. Examine for obvious physical damage, corrosion, leakage, or clogged nozzle.

7. Pressure gauge reading or indicator in the operable range or position.

8. Each department head shall assign primary and alternate employees to function as fire extinguisher monitors for making monthly inspections. The Departmental Safety Contact Personnel shall maintain logs to document corrective action taken on such fire extinguishers. The date and initials of monitor or alternate shall be recorded on the inspection tag. The primary employee for monthly health department inspections is the Environmental Health Supervisor or designee.

9. When an inspection of any extinguisher reveals a deficiency in any of the conditions listed above, the monitor or alternate shall take action by notifying their supervisor with the control number of the extinguisher and the nature of the problem.

10. Upon notification of defective extinguisher, the supervisor or department head will contact the purchase vendor and exchange the extinguisher or correct the deficiency.

E. Fire Safety Rules

This agency has developed fire safety rules for all staff and clients to the agency. Employees should be familiar with and abide by the rules.

1. Important points to remember for staff include:

    a. The location of all fire extinguishers and exits.
    b. Everyone is responsible for ensuring that exits are unobstructed at all times.
    c. Quickly collect personal items when notified to evacuate.
    d. Move quickly but orderly to the nearest exit.
    e. All corridors are to remain clear and unobstructed.
    f. Equipment must not restrict the corridor width greater than four feet. Additionally, all equipment must be kept on the same side of the corridor.
    g. Storage is not permitted in any fire exit or stairwell blocking exit.

2. Equipment used on a temporary basis to provide facility maintenance may be temporarily stored in the corridor if the corridor width is not restricted greater than four feet and the equipment operator is in control of the equipment at all times.

3. Electrical panels may not be blocked nor is equipment storage permitted within thirty-six inches of the panel.

4. Fire doors must never be blocked or wedged open.

5. Storage is not permitted within eighteen inches of a sprinkler head.

6. Flammables must be stored in an approved flammable storage area.

7. Fire extinguishers and fire hose connections must be kept free and clear at all times.

8. Fire extinguishers stored in the facility are located in the following areas:

    a. Middle reception area in front of management support supervisor office,
    b. Back of clinical hall near exit door at stairwell,
    c. PPC hallway – across from lab,
    d. Outside pharmacy door on hallway where WIC is located,
    e. Upstairs outside Family Care Coordination Room at top of stairwell,
    f. In the upstairs hallway near the water fountain,
    g. Dental Clinic – kitchen area, and
    h. Environmental Health

9. Smoke detectors/sensors are located within the duct system of the heating and air units.

10. The fire alarms are the manual activated alarms and are located downstairs in the front receptionist area, at the back of the General Clinic hall at the exit at the stairs, upstairs outside the Family Care Coordination Room at the top of the stairwell, and Environmental Health hallway near employee exit door.

F. Fire Drills

A fire drill is conducted at least once per year or as appropriate. The Health Director or designee is responsible for ensuring this requirement is met by each staff member. This will be in conjunction with the County Safety Risk Manager.

G. Training

Each staff member will receive training regarding the immediate emergency response, the fire alarm system, fire safety and the selection of fire extinguishers as part of the initial staff orientation. Annual review of this information is required for each staff member.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: SAFETY MANAGEMENT PROGRAM GUIDELINES

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/16

I. PURPOSE:

The Division of Public Health Services has adopted and implemented a Safety Management Program that is designed to minimize hazards in the delivery of agency services. The underlying intent of the safety management program is that safety management is the responsibility of each staff member at all times in the work place and when in or on county property. The focus of the program is the reinforcement of safety enhancing activities and the diminishing of accident promoting activities.

II. SCOPE:

All employees, department heads and supervisors are responsible for active participation in the health and safety program activities. All employees have the responsibility to perform their own work in a safe and efficient manner. It is the basic safety policy of Rockingham County that no task is so important that an employee must violate a safety rule or take a risk of injury or illness in order to get the job done.

1. The Division of Public Health Services will provide a representative to serve on the County Safety Committee.
2. The Division of Public Health Services and County Safety Risk Manager will provide initial and annual training for employees on Safety Guidelines and Agency/County rules.
3. Violation of work rules is a job performance issue and shall be dealt with through the Rockingham County Personnel Policy.

III. AUTHORITY AND REFERENCES:

Rockingham County Board of Commissioners has assigned the responsibility, authority and accountability for safety to all department heads, supervisory personnel and employees.

References:

- Rockingham County Government Employee's Safety and Health Handbook
- Rockingham County Government Emergency Response Plan Guide
- Rockingham County Personnel Policy Handbook
- Division of Public Health Services Safety Guidelines

IV. GUIDELINES:

A. Employees are required to comply with all County and Agency safety guidelines, safety rules, and OSHA Regulations. Employees are encouraged to actively participate in identifying ways to make the Department a safer place to work.

B. Department Head and/or Supervisor Responsibilities:

1. Support the Rockingham County Employee's Safety and Health Handbook, the Rockingham County Government Emergency Response Plan Guide and Agency Safety Guidelines.

2. Support staff participation in Agency safety meetings.

3. Support the allocation of sufficient employee time, management support and expenditure of funds for safety equipment, training and needed items to carry out the safety program.

4. Evaluate employees each year to assure they are carrying out their responsibilities as described in this program.

5. Assure that incidents are fully investigated and corrective action is taken to prevent the hazardous conditions or behaviors from happening again.

6. Assure that a record of injuries and illnesses is maintained and posted as described in this program.

7. Set a good example by following established safety rules and attending required trainings.

8. Report unsafe practices or conditions to the employee of the area where the hazard was observed.

9. Assure that each employee has received initial safety training during the process.

10. Assure that each employee is competent or receives training on safe operation of equipment or tasks before starting work.

11. Observe the employees working. Promptly correct any unsafe behavior. Provide training and take corrective action as necessary. Document on employee evaluations.

C. Employee Responsibilities:

1. Support the County Employee Safety and Health Handbook, County Emergency Response Plan and Agency Staff Guidelines, and OSHA Regulations.

2. Follow safety rules and Agency guidelines described in this program and trainings.

3. Report unsafe conditions, injuries or actions to the supervisor promptly.

4. Report all near-miss incidents to the supervisor promptly.

5. Use personal protective equipment (PPE) in good condition when it is required or recommended.

6. Do not remove any safety device or safeguard provided for employee protection.

7. Be a role model to co-workers by using safe work practices on the job.

8. Make suggestions to the supervisor about changes that will improve employee safety and provide a safer work environment.

D. Safety Coordinator (Staff Development Coordinator) Responsibility:

- Ensure that monthly safety inspections are performed.

E. Safety Committee Responsibilities:

The Division of Public Health Services has a team designated to serve as the Agency Safety Committee.

1. The Agency may schedule quarterly safety committee meetings to help employees and management work together to identify safety problems, develop solutions, review incident reports and evaluate the effectiveness of our safety program. Safety Committee members will be responsible for attending the meetings. In the event of an absence, the Safety Committee member will be responsible for reading the minutes of each meeting.

2. In addition to the safety meeting responsibilities explained above, duties of Safety Committee Members include:

   a. Monthly self-inspection of the area they represent.
   b. Communicate with the staff on safety issues.
   c. Encourage safe work practices among employees.

3. The Staff Development Coordinator will schedule the date and time of the quarterly meeting.

4. Review injury records and investigate incidents.

5. A Safety Committee member will be designated to keep minutes. Minutes will be available to employees. The minutes will be filed for three years.

F. Record Keeping and Review:

1. Employees are required to report any injury or work related illness to their supervisor regardless of how serious. The supervisor will call the County Safety and Risk Manager. Minor injuries such as cuts and scrapes can be entered on the minor injury log. The employee must use the "Rockingham County Employee's Report of Accident/Incident" form to report all injuries.

2. The Safety and Risk Manager will:

   a. Investigate an injury or illness.
   b. Review the "Rockingham County Supervisor's Accident Investigation Report" form.
   c. Determine from the Employee's Report, Supervisor's Investigation Report and any claim form associated with the incident, whether it must be recorded on the OSHA 300 Injury and Illness Log and Summary, according to the instructions for that form.
   d. Enter a recordable incident on the OSHA 300 Injury and Illness Log and Summary within seven days after the department becomes aware of it.
   e. Add the injury if not recorded on the OSHA log to a separate incident report log which is used to record non-OSHA recordable injuries and near misses.
   f. Post a signed copy of the OSHA log summary for the previous year on the safety bulletin board each February 1 until April 30. The log will be kept on file for at least five years. Any employee can view an OSHA log upon request at any time during the year.

G. 1. If an employee dies while working or is not expected to survive, or when an employee is admitted to a hospital (in-patient) as a result of a work-related incident, the supervisor will contact the Safety and Risk Manager immediately.

2. The Health Director or designee must report:

   a. Employer name.
   b. Location and time of the incident.
   c. Number of employees involved.
   d. Extent of injuries or illness.
   e. Brief description of what happened.
   f. Name and phone number of a contact person.

3. DO NOT DISTURB the scene except to aid in rescue or make the scene safe.

4. Whenever there is an incident that results in death or serious injuries that have immediate symptoms, a preliminary investigation will be conducted by the immediate supervisor of the injured person(s), the Safety and Risk Manager, a person designated by management, and any other persons whose expertise would help the investigation.

5. The investigation team will take written statements from witnesses, photograph the incident scene and equipment involved. The team will also document as soon as possible after the incident the condition of equipment and anything else in the work area that may be relevant.

6. The team will make a written Incident Investigation Report of its findings. The report will include a sequence of events leading up to the incident, conclusions about the incident and any recommendations to prevent a similar incident in the future. The report will be reviewed at the safety meeting at its next regularly scheduled date.

7. When the Health Director becomes aware of an employee injury where the injury was not serious enough to warrant a team investigation as described above, the supervisor will complete a "County Supervisor's Accident Investigation Report" to accompany the "County Employee's Report of Accident/Incident" and forward them to the Safety and Risk Manager and the Staff Development Coordinator.

8. Whenever there is an incident that did not, but could have resulted in serious injury to an employee (*a near-miss*), the incident will be investigated by the Supervisor of the Division or Safety Risk Manager or a team depending on the seriousness of the injury that would have occurred.

    a. The "County Supervisor's Accident Investigation" report and "County Employee's Report of Accident/Incident" will be used to investigate the near miss.
    b. The form will be clearly marked to indicate that it was a near miss and that no actual injury occurred.
    c. The report will be forwarded to the Safety and Risk Manager to record on the incident log.

H. Safety Inspection Procedures:

1. Rockingham County Division of Public Health Services is committed to aggressively identifying hazardous conditions and practices that are likely to result in injury or illness to employees.

The Department will take prompt action to eliminate any hazards that are found.

2. In addition to reviewing injury records and investigating incidents for their causes, the Safety Committee Management Team and the Safety Coordinator will regularly check the workplace for hazards as described below:

   a. *Monthly Safety Inspection* –Each month, the Safety Coordinator or designee will inspect designated areas for hazards using the standard safety inspection checklist. He/She will talk to workers about their safety concerns. Occasionally, Safety Coordinators may agree to inspect each other's area rather than their own. This brings a fresh pair of eyes to look for hazards.

   b. *Job Hazard Analysis* – As part of our on-going safety program, we will use a "Job Hazard Analysis" form to look at job tasks that employees do. The employees who perform the task will do the analysis. How the job is done will be changed as needed to eliminate or control any hazards. With the Job Hazard Analysis the job will be checked to see if the employee needs to use personal protective equipment (PPE) while doing the job. Employees will be trained in the revised operation and how to use any required PPE. Job tasks will be analyzed whenever there is a change in how the task is done or if there is a serious injury while doing the task.

I. Eliminating Workplace Hazards:

The Division of Public Health Services is committed to eliminating or controlling workplace hazards that could cause injury or illness to our employees. The Department will meet the requirements of state safety standards where there are specific rules about a hazard or potential hazard in the workplace.

1. <u>Exposure Control Plan</u>

   All exposures to blood or body fluids to which universal precautions apply will be handled according to the Division of Public Health Services' Report of Exposure Form. This form is found in the Division of Public Health Services OSHA Manual.

   All work related employee injuries resulting in lost time or medical expenses are reported to Risk Management.

2. <u>Building and Environmental Safety</u>

   a. Positioning of equipment will be planned so as to decrease possible injury of employees and clients. All unnecessary

trash, equipment, and supplies will be removed immediately from hallways, high traffic areas, and fire exits.

b. Emergency exit signs will be maintained at exits and hallways. Safety, fire, and disaster training will be conducted routinely. Emergency exits shall not be locked from the inside during working hours.

c. Hazardous chemicals shall be contained in properly labeled containers and staff will be informed of the presence of any hazardous chemicals/substances as required by the Hazard Communication Station.

3. Zero Tolerance for Workplace Violence

a. The Division of Public Health Services employees should follow the Rockingham County Government Emergency Response Plan Guide in reporting violence/threats in the workplace. Employees should take the following steps:

- Anytime an employee feels threatened they should report the threat to their Supervisor, Director and/or Personnel Director.
- If an employee feels threatened or observes another person is in danger due to an uncontrollable person, they should make the "Disruptive Client" announcement for assistance by:
  - Dial the supervisor or designee
  - Speak clearly and say, "Disruptive Client – *location*" (give the office area or location where the disturbance is occurring). Example: "Disruptive Client in the Main Lobby". Repeat this 2 to 3 times.
- Call 911.

b. The Division of Public Health Services will have zero tolerance towards workplace violence against workers. The Division of Public Health Services prohibits disrupting, interfering, or preventing normal work functions or activities; making physical or verbal threats; or endangering the health or safety of any individual.

- Disruptive behaviors include yelling, using profanity, waving arms or fists, verbally abusing others, and refusing reasonable requests for identification.
- Threatening behaviors include physical actions short of actual contact or injury (i.e., moving aggressively into another person's personal space), general oral and written threats (in person or via electronic means) to people or property, and implied threats.

- Violent behaviors include any physical assault (with or without weapons), behavior that a reasonable person would interpret as being potentially violent or specific threats to inflict physical harm.

c. Violations of this policy by any individual will lead to disciplinary action which may include permanent discharge from the facility and/or criminal prosecution as appropriate. When a worker has experienced workplace violence the violator(s) of this policy shall leave or be removed from the premises as quickly as safety permits and shall remain off of the Rockingham County Governmental Center premise for the next 24 hours or pending the investigation of the incident. Any appointments the client has on that date of service will be cancelled.

V. LOCKDOWN PROCEDURE:

A. Responsibility of All Staff When an Active Shooter/Assailant Alert is Heard:

1. Go to assigned Safe Room in your department or if unsafe for you to move, stay where you are and lock or block the door. Turn off the lights and silence your cell phones and stay as quiet as possible. Then call your Safe Room or supervisor and report your location. Each employee is to escort clients and visitors with them into their assigned Safe Room. Have clients silence their cell phones and instruct them to remain quiet. Do not go into the area of disturbance if it is your designated safe area; go to the next safe area.
   - Second Floor – Health Department staff report to the FCC area.
   - Second Floor – Dental Clinic staff remain in Dental Clinic area and all entry doors should be locked by designated staff member (receptionist).
   - Pharmacy – Remain in Pharmacy and lock all entry doors by the Pharmacist on duty.
   - First Floor – Staff and visitors utilize lockable offices on WIC hallway or any exam rooms on Clinic hallway. All front management support staff will go to nearest first floor areas. All visitors in general clinic waiting area will be placed in the Government Center break room with designated agency staff. Agency staff will lock all entrances that are lockable.
   - Environmental Health – Move to lockable offices and lock entry doors.
2. Safe Rooms are to be locked once all staff can be accounted for. This should be done within 2-3 minutes of alert. Once the Safe Room door is locked it is not to be opened for ANYONE.

3. Call 911 and give your Safe Room location. Confirm who is in the Safe Room and provide name(s) of anyone not accounted for on your list. Keep phone lines open in case authorities need to contact you with emergency information.
4. Remain in the Safe Room until emergency personnel rescue you or your supervisor or their designate announces ALL CLEAR.
5. If employee/clients can be evacuated safely, follow the designated bomb threat evacuation routes.

B. Maintaining Employee Safety:

a. See the County Employee Safety and Health Handbook for the following:

- Electrical Safety (pg. 20)
- Prevention of Falls (pg. 21)
- Housekeeping/Sanitation (pg. 23)
- Safe Lifting (pg. 29)
- Motor Vehicles (also reference Rockingham County Vehicle Policy) (pgs. 32-35)
- Office Safety (pg. 36)
- Ergonomics (pg. 38)
- Computer Work Station (pg 38)

b. See the Division of Public Health Services Guidelines for:

- Tornado/Severe Weather
- Emergency Evacuation (Fire & Bomb Threat)
- Fire Prevention

Note: Evacuation Routes and Plans are posted throughout the health department.

C. Office Visits After Hours:

1. The Division of Public Health Services encourages all employees to utilize the office during normal operating hours and minimize trips to the agency after hours.

2. If an employee must enter the agency office after 5:00 p.m. or anytime on weekends or holidays, the following safety tips should be followed to maximize personal safety:

a. Place personal items that appear to have value (i.e. purse) in the trunk of the car before going to the agency.
b. Survey the territory surrounding the agency from within your locked car for suspicious vehicles, groups of people, animals, or unusual circumstances. Leave the area if you feel unsafe and contact the police for an escort before returning.

c. Have agency key or name tag ready to unlock the door.
d. Lock vehicle when exiting car.
e. Proceed to the agency main entrance.
f. After entering the agency, close locked door behind you.
g. Sign in at the desk in the front lobby.
h. Upon leaving the agency, survey the area around the doorway and your car before leaving the building and have your keys ready.
i. Remember to sign out at the front desk.
j. Lock the car door as soon as you have entered the car.

D. Field Safety and Home Visiting Tips:

1. Avoid confrontations and threatening situations whenever possible. If threatened, end it as quickly as possible. If a situation does not "feel right", leave immediately.

2. Before entering the field and home, review any relevant records/data for history of hostility, mental disorders, criminal activity, vicious dogs, etc.

3. Always follow "sign out" procedure. List destination and projected time of return.

4. Park your vehicle as near to your destination as possible and park so that your exit cannot be blocked.

5. Before leaving your vehicle, notice signs of any domestic arguments, gang activity, drunkenness, vicious dogs, etc. If there are any signs, leave the scene and return later.

6. Call for police protection if needed prior to or during visit.

7. Avoid arguments. When others direct insulting remarks at you, ignore them. If the situation continues leave the area.

8. Instruct client/family to secure dogs prior to your visit. If they refuse, visit may be delayed. If attacked by a dog, do not turn back or try to run. Use anything as a shield.

9. When approaching a dog, walk confidently but non-aggressively. Always give a dog room to run; do not back them into a corner.

10. When you knock on a door or ring a doorbell, stand to one side and wait for someone to answer the door. Do not enter if someone yells "come in".

11. For work in threatening environments, consider working in pairs.

12. When in high-risk areas, check in by phone before and after visit. Set time limits for each visit.

VI. SAFETY TRAINING:

1. Training is an essential part of our plan to provide a safe work place at the Division of Public Health Services.

2. To assure that all employees are trained *before* they start a task that requires training, the Safety and Risk Manager will be available to conduct appropriate training.

3. The Safety and Risk Manager is responsible to verify that each employee of the Division of Public Health Services has received an initial orientation, has received any training needed to do the job safely and that the employee file reflect the documentation of the training.

VII. REVIEW OF GUIDELINES:

The Management Team and/or the Safety Coordinator will review this Guide annually. Staff will be informed of any revisions.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: TORNADO AND SEVERE WEATHER GUIDELINES

DATE DEVELOPED: 1999
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 3/23; 6/23; 6/24
REVISED: 6/15; 3/23

I. PURPOSE:

To ensure safety measures for the employees and clients of the Division of Public Health Services during a tornado/severe weather event.

II. SCOPE:

The Division of Public Health Services will provide mock tornado/severe weather drills and provide training for the staff on maintaining safety within the work setting during the time of a tornado warning or tornado watch or severe weather. The County Emergency Response Program Guidelines will be followed at the time of the warning.

III. AUTHORITY AND REFERENCES:

Rockingham County Board of Commissioners has assigned the responsibility, authority and accountability for safety to all department heads, supervisory personnel and employees.

References:

- Rockingham County Government Employee Safety and Health Handbook
- Rockingham County Emergency Response Plan Guide
- FEMA

IV. GUIDELINES:

A. Definitions: According to FEMA Guidelines

1. Tornado watch - Conditions are conducive to the development of tornadoes in and close to the area.
2. Tornado warning - A tornado has actually been sighted by spotters or indicated on radar and are either occurring or imminent in the warning area.
3. The Wentworth Fire Department uses a solid, one-minute signal for a tornado warning. Be alert to the difference in the tornado signal vs. the fire signal.

B. The agency will provide training upon hire and annually on the proper steps to take in the event of a tornado.

C. The following health department staff has accessible means to monitor weather conditions.

1. Health Director
2. Environmental Health Director
3. Clinical Nursing Supervisor
4. Public Health Preparedness Coordinator
5. Director of Nursing

D. The following individuals have the authority to announce the watch or warning:

1. County Manager
2. Assistant County Manager
3. EM Director or Safety & Risk Manager

E. The following steps will be taken in the event of a tornado watch:

1. Key staff members will notify the program supervisors of the watch.
2. Supervisors will begin preparation and expect the need to evacuate.
3. The Director of Nursing, Preparedness Coordinator and Team 3 Leader will be issued an orange emergency bag and flashlight to take to their designated locations. Walkie-talkies will be issued to shelter area managers and the Director of Nursing for communication throughout the event. Cell phones may be used for communication.
4. Staff will be instructed to plan to take only essential items to the evacuation area.

F. The following steps will be taken in the event of a tornado warning:

1. The County Safety Risk Manager, Personnel Purchasing Director, Finance Director or designated person will announce the Tornado Warning. Staff shall be instructed to assist the public and clients into the evacuation areas designated for their department.
2. Employees and clients will be directed to the following areas and instructed to report quickly and close all doors as they exit:

    a) Employees and clients in the waiting room, registration area, front offices, lab, and general clinic treatment rooms (immunizations, primary care, child health, and triage) will report to the general clinic hallway and/or its <u>interior</u> treatment rooms or offices. No one should remain in rooms located on the outside wall.

- The PHN Supervisor II, Team 1 Leader, or a clinical staff member will assist clients and employees into the shelter area and assume the role of shelter manager. As shelter manager they will:

  - Oversee cooperation and coordination of the shelter area.
  - Instruct the group to assume the crouch position, face the wall, and cover head with their hands.

- The foreign language interpreter shall remain in this area and provide interpretation services as needed.

b) Employees and clients in the primary care and family planning area will remain within the hallway or treatment rooms.

- The PHN Supervisor I, Team 2 Leader or designee will assist clients and employees into this shelter area and assume the role of shelter manager. As shelter manager they will:

  - Oversee cooperation and coordination of the shelter area.
  - Instruct the group to assume the crouch position, face the wall, and cover head with their hands.

- The foreign language interpreter assigned to family planning will remain in family planning area if needed for interpretation.

c) Employees and clients located in the WIC hallway and private clinical staff offices will exit the office, close the door and stay along the inner side wall of the hallway. Second floor Family Care Coordination, communicable disease and preparedness staff will also report to this hallway.

- WIC Director, Team 3 Leader or designee will assist clients and employees into the shelter area and assume the role of shelter manager. As shelter manager they will:

  - Oversee cooperation and coordination of the shelter area.
  - Instruct the group to assume the crouch position, face the wall, and cover head with their hands.

d) Main Floor Management Support Staff will report to pharmacy back office space away from the drug shelves.

- The Office Work Unit Supervisor will evacuate clients from the restrooms to the WIC hallway area and will report to the pharmacy.
- The Pharmacist or Office Work Unit Supervisor will assume the role of shelter manager. As shelter manager they will:

  - Oversee cooperation and coordination of the shelter area.
  - Instruct the group to assume the crouch position, face the wall, and cover head with their hands.

e) Environmental health staff will locate in the hallway outside of the public bathrooms. The Environmental Health Director or Program Manager will be responsible for ensuring that employees and clients are taken to the designated shelter area.

f) Second Floor Staff/Dental Staff—all upper level administrative staff and visitors will be assisted to the lower level to locate within the family planning and primary care hallway.

g) The first floor employee break room has been designated as the governmental center command post. The following staff should report to that area and take the following equipment with them:

* Health Director – 800 MHZ Radio/cell phone
* Director of Nursing – Orange emergency bag/flashlight
* Environmental Health Supervisor – 800 MHZ radio/cell phones
* Accounting Specialist- Note pad and pens.

The Health Director or designee will make a quick walk through of the second floor to ensure compliance (evacuation) before locating to the command center.

The Director of Nursing or designee will make a quick walk through of the clinical areas and WIC hallway to ensure compliance (evacuation) before locating to the command center.

The Office Work Unit Supervisor will make a quick check of the waiting room, and public restrooms to ensure compliance before locating to the pharmacy.

G. Public Health supervisory staff will ensure the following:

Tornado Watch

1. Supervisors should remind their employees of the designated shelter area, and to immediately evacuate should a warning be issued.
2. Supervisors are advised to keep a current employee list with cell and/or car radio numbers and a work schedule easily accessible in the event of a warning announcement.
3. The supervisor will be responsible for contacting the field staff to alert them of the watch. They should advise their staff to monitor a radio or television in case a tornado warning is issued. If a warning is issued they should seek shelter at their present location, if possible. They will be notified by cell phone or car radio when the alert is over.

Tornado Warning

1. Upon warning announcement, the supervisor should make a quick walk through to ensure evacuation of their work area. Each supervisor will be responsible for having a log that provides the names of the employees that have signed out of the building.
2. The supervisor shall take their list of employees with cell phone and/or car radio numbers to the shelter area.
3. The supervisor will conduct a head count to ensure all employees are accounted for. Any missing staff will be reported to the shelter manager. The shelter manager will notify the Director of Nursing by two-way radio.

H. **Shelter Management -** The designated shelter manager or team leader will be responsible for their designated shelter area and ensuring the following:

1. Oversee cooperation and coordination of their assigned area.
2. Instruct their assigned group to assume the crouch position on the floor, facing the wall, and placing their hands over their heads.
3. Encourage their group to remain calm, and remain in the area until the warning has been discontinued.
4. Instruct staff not to leave the building until the warning has been discontinued. It is understood that someone cannot forcibly be held against his/or her will, therefore it is understood that the employee is

assuming full responsibility for his/her own actions in leaving the facility.

5. Document the name of the employee and the time they leave the building if leaving before the all clear signal is announced.
6. Instruct clients/public not to leave the building until the warning has been discontinued. It is understood that someone cannot forcibly be held against his/her will, therefore it is understood that the client/public is assuming full responsibility for his/her own actions in leaving the facility. It should be documented by the shelter manager the name of the person(s) and the time they leave the building if leaving before all clear signal is announced.
7. Instruct occupants of your shelter area to stay away from the windows and close all doors or rooms that are not being used for a shelter area.

I. The Health Director, Director of Nursing, Environmental Health Director and Accounting Specialist will be posted in the first floor command center (employee break room). Command center staff will be continuously monitoring the radio or television and will be in contact with the shelter managers on the processes and events of the storm by two-way radio or cell phone.

J. All staff should listen for announcements from the proper authorities that the warning has been canceled and it is clear to return to work areas. The County Safety Risk Manager, Personnel Purchasing Director, Finance Director or designated person will make the announcement. Staff should assist the public and clients as needed back to the department.

K. If the tornado has caused damage at any location, request no one leave the shelter area until given authority to do so. Do not allow employees or clients to wander about until safety has been ensured. This could be timely, depending on the severity of the damage.

L. Instruct evacuation of the damaged area in a safe manner with assistance provided. Avoid downed power lines and report any problems. Be aware of possible structural, electrical or other hazards.

ROCKINGHAM COUNTY DEPARTMENT
OF PUBLIC HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

SEXUALLY TRANSMITTED DISEASE/HIV-AIDS

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SEXUALLY TRANSMITTED DISEASES

DATE DEVELOPED: 5/2000
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/22

I. POLICY:

The professional staff of the Division of Public Health Services Family Planning/ STD Program Clinic provide sexually transmitted disease screening and treatment to any client who requests these services, or to any client whose health history or lifestyle/risk behaviors indicate the need for such testing. The Division of Public Health STD Program provides significant risk reduction counseling for clients at risk for Sexually Transmitted Infections through provision of condoms and supplementary culturally and age appropriate patient education materials to reduce the spread of HIV and STDs. The health department will offer required HIV, STD, TB and all other reportable communicable disease services at no cost to the client regardless of the client's county of residence**.** Privately insured clients requesting HIV/STD services may authorize billing of their insurance carrier; however, refusal to permit insurance billing shall not prevent the client from receiving services. Exceptions to the billing rule include: (a) clients who request optional STD testing which is not required or funded by the state (e.g., herpes serology) and (b) clients who receive follow-up treatment of genital warts after the diagnosis is established. Clients in these categories may be billed for testing and screening according to DHHS-Public Health billing policy for Adult Health services. According to General Statute 90-21.5, a minor may consent to medical services for the prevention, diagnosis, and/or treatment of any disease reportable under General Statute 130A-135. All clients seeking STD services will receive or be offered on site diagnostic and treatment services from appropriately trained staff. The clinic will provide HIV testing as a routine part of STD evaluation unless the client declines to be tested. Conversely, clinics evaluating persons for HIV will provide STD testing as a routine part of HIV evaluations.

II. PURPOSE:

The Family Planning/STD Program clinic, as well as Physician Extenders within the agency will follow the current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program – Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP).

Rockingham County DHHS-Division of Public Health HIV/STD Program strives to control the spread of sexually transmitted diseases among the population of

Rockingham County, by screening all clients requesting these services; by the clinicians' assessment of a client's risk factors, indicating the need for STD screening, based on information given by the client to the interviewing professional; and, as a routine part of the family planning physical exam/ preventive clinical visit or other clinical visit as indicated by history. The purpose is to protect the client's health, by diagnosing and treating positive STD test results. Following the current MMWR guidelines, the prevention and control of STDs is based on these major concepts:

- Education and counseling of persons at risk on ways to avoid STDs through changes in sexual behaviors and use of recommended prevention services;
- Identification of asymptomatically infected persons and of symptomatic persons unlikely to seek diagnostic and treatment services;
- Effective diagnosis, treatment, and counseling of infected persons;
- Evaluation, treatment, and counseling of sex partners of persons who are infected with an STD; and
- Pre-exposure vaccination education/counseling of persons at risk for vaccine-preventable STDs.

Goals of the RCDHHS-Division of Public Health HIV/STD Program are to:

- Prevent STI-related infertility
- Prevent STI-related adverse outcomes of pregnancy
- Prevent STI-related cancers
- Prevent STI-related HIV transmission
- Strengthen STD prevention capacity and infrastructure; reduce STD incidence
- Reduce STD health disparities across and within communities and populations; increasing STD services for at risk populations
- Address the effects of the social and economic determinants and costs of specific STDs and associated sequelae among specific populations
- Improve the integration of STD services in the clinical care setting
- Minimize the threat of antibiotic resistant Gonorrhea.

Concentrated Focus areas of STD Prevention for maximization of long term impact are:

a. Adolescents and Young Adults-Sexually Transmitted Diseases primarily affect young people with health consequences that can last a lifetime.
b. Men Who Have Sex with Men (MSM) - MSM are impacted by HIV/AIDS, Syphilis, and Gonorrhea at concerning rates.
c. Multi-Drug Resistant Gonorrhea- Data continue to show concerning patterns of declining susceptibility to Cephalosporins the only remaining Gonorrhea treatment.
d. Congenital Syphilis-Syphilis infection is a serious concern for pregnant women, as it can cause stillbirth and lead to physical and mental developmental disabilities in babies.

All STD clients receive assessment of vaccine status with recommendation of vaccination for vaccine-preventable sexually transmitted diseases as assessed. Services include thorough assessment of vaccination status, education/ counseling on vaccines needed and referral to on-site immunization clinic for vaccination based upon current ACIP guidelines.

III. GUIDELINES:

A. Walk-in STD clients are seen on a daily basis if schedule permits, or within 24 hours. Clients are instructed to see a private medical doctor, urgent care or seek emergency services when symptoms are acute and the clinic is closed. Clients that request evaluation due to symptoms of sexually transmitted disease or report exposure to a sexually transmitted disease will be seen within one work day. Clients that call in are triaged by a nurse in Family Planning/STD Clinical Program to assess urgency for appointment. Asymptomatic/non-exposure walk in clients requesting screening who are not able to be scheduled for
examination on the day they come in to the health department are given a first available appointment or provided STD medical resources and eligibility requirements. The health department has written policies covering all aspects of STD service delivery.

A STD client is any individual presenting with one or more of the following: genital lesion(s) or other lesions suggestive of a sexually transmitted infection (STI), genital discharge, a partner with genital discharge or genital lesion(s) or other symptoms suggestive of a sexually transmitted infection, a partner receiving or having received treatment for a sexually transmitted infection; referral by a Disease Intervention Specialist (DIS); a positive test for a sexually transmitted infection; referral by community health care provider (Federally Qualified Health Center, private practice, local hospital, other) or individuals presenting for the purpose of testing or screening for sexually transmitted infection.

*Note: The exposure time frame for referral is for all sex partners exposed to urethritis, cervicitis, and related infections within the last 60 days (treat most recent partner(s) if interval exceeds 60 days). Sex partners must be examined, tested and receive treatment.

Provide essential STD services which are defined as taking a medical history including sexual risk assessment, a physical examination inclusive of the upper and lower body, laboratory testing, treatment, counseling, and referral necessary for the evaluation of individuals with an exposure to or symptoms suggestive of a sexually transmitted infection. In the public health setting, this would include primary prevention such as STD screening in asymptomatic clients based upon the client's site(s) of exposure.

Appropriately trained staff refers to MDs, DOs, NPs, PAs and STD Enhanced Role Registered Nurses (STD ERRNs) and Registered Nurses (RNs) providing essential STD services.

Clients receiving STD services will be evaluated and treated in accordance with current guidelines of the NC STD Public Health Program – CDC, DSTDP. Standing Orders will be current, aligned with actual practice, readily available in the clinical setting, and signed annually by the RCDHHS-Division of Public Health Medical Director for RN and STD ERRN providers.

B. Services Provided:

Medical History of client including sexual risk assessment;

Physical examination of client inclusive of the upper and lower body, collecting specimens needed as determined by exposure, symptoms, and tests as listed in individual disease standards;

Laboratory tests – If an STD client has not had an STD screen within the last 30 days – one will be performed;

Treatment as indicated by verified exposure, symptoms and laboratory test results;

Counseling on disease process, medication, prevention, risks, and contacts; Referrals to available outside sources, as with a positive HIV client; Referrals to community medical resources, primary care physician (PCP), etc., if the client's assessment indicates the need for intervention.

Condoms are offered to all clients seeking services in STD program, all Family Planning clients determined to be at risk of Sexually Transmitted Infections based on assessed sexual health history/risk factors and to clients seen in other health department programs as determined by evaluation in these programs. Condoms are also provided to any citizen presenting to the health department requesting this service. Condoms are provided with supplementary STD patient education materials to aid in reducing the spread of HIV and STDs, as well as education on correct procedure for use to promote consistent condom usage. Clients seen in STD Program who decline condoms with use recommended based on sexual health history/risk factors will sign the Division of Public Health Services declination form.

The Division of Public Health Services does not provide prenatal care. Clients known to be pregnant who present to the Division of Public Health Services STD Program seeking screening or treatment services will be referred to their primary prenatal provider for services. Clients who are determined to be pregnant but are not yet in prenatal care will receive

Family Planning program information and offered pregnancy options counseling with referrals as requested. (See FP-2 Pregnancy Diagnosis and Counseling Policy.)

C. Performance Measures:

1. The Division of Public Health Services will assure availability of clinic appointments and accessibility of appropriately trained staff is adequate to meet the needs of the number of clients requesting STD services.

2. The Division of Public Health Services will ensure that the STD ERRN maintains competency to perform evaluation, testing, treatment, counseling and referral of clients seeking care for sexually transmitted infections through ongoing local health department quality assurance monitoring and through Communicable Disease Branch Regional Nurse Consultant monitoring.

3. The Division of Public Health Services will ensure the STD Enhanced Role Registered Nurse (STD ERRN) training course is completed by all Registered Nurses who provide clinical assessment and management of clients with STD concerns. After completion of initial STD ERRN training, the skill level of each nurse must be maintained through an acceptable level of practice and observation. An acceptable level of practice is assessment and management of at least 50 STD male and female clients per calendar year and 10 hours of relevant clinical continuing education every calendar year.

4. Alternatively, if the annual practice hour assessment and management requirements cannot be met locally, the STD ERRN shall contact the Regional Technical Assistance and Training Program (TATP) Nurse Consultant no later than November 1, each year to develop an alternative plan to meet the requirements. Exceptions to this requirement for assuring continuing competency will be considered on a case-by-case basis by making a request in writing to the Technical Assistance and Training Program Supervisor or designee.

5. Ensure all newly hired STD medical providers shall participate in required trainings:

   a. The Division of Public Health shall notify the CDB Nurse Consultant within 15 days of hiring a new STD medical provider. Each new STD medical provider shall complete clinical practicum activities as directed by the regional TATP nurse consultant within 6 months of employment.
   b. The Division of Public Health Services will assure that within six (6) months of employment, all newly hired

medical providers who perform clinical assessments and management of clients with STD concerns have completed:

- Observations of an experienced STD clinician performing at least one male and one female STD assessment. The observation of the male assessment must include components of a MSM exam. An experienced STD clinician is defined as a Physician, an Advanced Practice Provider (APP), or an STD ERRN with at least one year of experience in an LH
- Assessment of one male and one female STD client under the observation of an experienced STD clinician.

c. All newly hired medical providers who perform clinical assessments and management of clients with STD concerns are to complete online training when it becomes available, i.e. National STD Curriculum online training courses; Alabama/North Carolina Prevention Training Centers online STD training courses.

d. Ensure that currently employed STD clinical providers with the LHD participate in the observation experience as described above and complete online training when it becomes available as described above.

D. Reporting Requirements:

1. The Division of Public Health Services will submit a *STD Services Access/Availability Data* report (current list of names of all STD medical providers and STD ERRNs) electronically to the CDB Regional Nurse Consultant by January 15th of each year for the previous calendar year (January 1-December 31).

2. The Division of Public Health Services must submit electronically a list of STD ERRN providers, the date the initial STD Enhanced Role training was completed, a list of continuing education courses with number of relevant contact hours completed for each course, the total number and gender of STD clients assessed, and the dates of STD PTC courses attended, if applicable. Documentation of practice and continuing education will be reported annually, no later than January 15th of each year for the previous calendar year (January 1-December 31) using the form: *STD ERRN Continuing Education and Skill Maintenance Verification.*

3. The Division of Public Health shall document annual observation of each STD ERRN by an STD medical provider or by peer review from another STD ERRN using the STD ERRN Clinical Assessment Tool. If deficiencies are noted, documentation of a corrective action

plan should be sent to the CDB Regional Nurse Consultant for review within 15 days.

4. The Division of Public Health Services must be able to list clients seen by each STD service provider using a unique identifier such as the Local Health Department medical record number. Release of the lists shall be required upon request by the Regional CDB Nurse Consultant for program audits.

5. The Division of Public Health Services will enter treatment specific data into the NC EDSS. Clients seen in any Health Department clinic with a positive test result for Chlamydia or Gonorrhea will have data entered into NC EDSS within 30 days of **test results** date or within 30 days from the date of report to public health from a non-health department provider.

6. For Clients diagnosed with Chlamydia or Gonorrhea in any Health Department clinic, 85% or more of the clients should receive appropriate treatment within 14 days of the receipt of test results date and 95% or more of the clients should receive appropriate treatment within 30 days of the receipt of test results date. Reports of STDs must be entered in the NCEDSS within 30 days of receipt of test results date. NC EDSS data is entered by the Communicable Disease Coordinator, Administrative Assistant**,** or other designated/ trained staff.

E. <u>Community/Client Education:</u>

1. In the clinical setting, STD brochures are given to the clients, as well as professional counseling provided by the Family Planning/ STD program clinical staff. All clients seeking STD services in the STD program are offered culturally and age-appropriate STD education.

2. In the community setting, the Division of Public Health Services Health Educators provide education at schools, whether it is in classrooms, or one-on-one counseling with a student. This is accomplished by the school requesting these services from our Health Educators. Churches may request specific health education programs to be presented by our Health Educators. Participating in health fairs is another community outreach effort.

3. The Division of Public Health Services will provide client-centered HIV counseling based on the State's Counseling, Testing and Referral (CRT) Training Curriculum for clients who are HIV positive or for any other client who requests HIV testing, counseling and referral services. All Division of Public Health Services staff providing positive HIV test results to clients must attend the CDB-

sponsored CTR training. The Division of Public Health Services shall have at least two staff trained at all times to meet service delivery needs.

F. Recruitment and Outreach Services for Clients: this is aimed at recruiting those individuals who are not already a Family Planning or STD client. This recruitment is done through:

1. Schools
2. Department of Social Services
3. Hospitals
4. Private physicians
5. Mental Health Clinic
6. Community contacts, as through health fairs
7. Public health nurses
8. Other county health departments
9. Through receipt of paper and electronic reports of positive STD clients

G. Composition of Family Planning/STD clinical staff:

1. The RCDHHS-Division of Public Health Services will have qualified staff to conduct on site STD evaluations, including male and female assessments, and to provide treatment, including injections, with standing orders for STD ERRNs or per Physician Extender orders.

2. Advanced Practice Provider: this Advanced Practice professional performs complete physical exams, performs STD testing, evaluation, and treatment, within the scope of the nurse practitioner's/Physician Assistant's practice.

3. Nursing supervisor/R.N.: this individual performs STD/screening including medical history, assessment for risk factors, physical examination, testing, counseling, and referral to Physician Extender, as needed. The PHN II is a STD Enhanced Role Nurse certified in STD screening including medical history, assessment for risk factors, physical examination, testing, counseling and referral to Physician Extender as needed.

4. LPN: This FP/STD clinical staff member assists the STD ERRN or Physician Extender in completion of the physical examination. This staff member may complete the medical history/interview for the Physician Extender or STD ERRN as needed, complete laboratory test requisitions and administer treatment per Physician Extender orders.

5. The Division of Public Health Services will ensure the STD Enhanced Role training course is completed by all nurses who provide clinical assessment and management of clients with STD concerns and that up-to-date standing orders and protocols are signed and available to guide practice.

6. Interpreter/MOA: this individual interprets for our Hispanic clients, in order to serve this population, as needed; to prevent a language barrier from interfering with this population's ability to obtain STD services. This person may also assist with obtaining height/weight and vital signs for the Family Planning/STD clients. This position also assists with MOA duties, such as assisting the practitioner and nursing staff during procedures and maintaining stock within the treatment rooms.

7. All staff will sign a confidentiality statement form upon employment, at the six-month probationary performance evaluation, and annually, thereafter. All employees receive annual training on confidentiality and cultural sensitivity.

8. The Division of Public Health Services' Medical Director provides oversight for the Sexually Transmitted Disease Program as well as all other health department programs. STD Program policies are reviewed/revised annually and as indicated based on new recommendations/guidance from the North Carolina Sexually Transmitted Diseases Public Health Program-Center for Disease Control and Prevention Division for Sexually Transmitted Diseases Prevention. Policies and standing orders are reviewed and signed by the Medical Director annually.

H. Division of Public Health Services Laboratory Services: All functions of this laboratory facility are regulated by the Clinical Laboratory Improvement Amendments (CLIA). The following STD lab tests may be performed and/or specimens obtained for submission to NC State Laboratory of Public Health (NC SLPH) or outside reference labs from the Division of Public Health Services' clinical laboratory:

1. Hepatitis A, B, and C screening
2. HIV testing (4th generation HIV screening assay)
3. RPR for syphilis/RPR Titer (if RPR reactive)
4. Gonorrhea culture (onsite), with confirmation to NC SLPH
5. Stat urethral Gram Stains (onsite)
6. Herpes culture
7. Wet mount (onsite)
8. Urine/Vaginal NAAT specimen for gonorrhea and chlamydia testing
9. Microscopic spin-down of urine (onsite)
10. Urine Pregnancy Test if questionable menstrual history (onsite), serum HCG as indicated per Physician Extender order

11. Expedited (Fast Tracked) HIV Testing when clients present with conditions and histories compatible with acute HIV infection (see lab protocols for procedure and criteria).
12. HSV I, II Serology
13. NAAT urine specimen for Trichomoniasis testing

The Division of Public Health Services' laboratory has its own policies, procedures, and standards of operations, which are located in the lab space.

I. Universal Precautions are observed by all clinical personnel for all clients as part of routine infection control. The following are the standards of practice used by all personnel, working in the clinical or laboratory areas.

1. Universal precautions apply to all body fluids when there is potential for exposure; all body fluids are treated as a potential source of infection.

2. Protective barriers are appropriate for the type of exposure anticipated, and may include latex, nitrile or vinyl gloves, gowns, masks, and protective eye wear.

3. Needles and syringes are never recapped or removed from disposable syringes, after use. In administering injections, the clinical staff uses approved safety needles/syringes.

4. All sharps are disposed of in the approved sharps containers, available in every exam room, in which injections are given, and in the laboratory, as well. These sharps containers are not to be filled over two-thirds full; when maximum level is reached, the top to the sharps container is snapped shut, and top is taped as well. These filled sharps containers are incinerated through contract services.

5. Gloves are worn by the lab staff in handling any specimens. The lab staff changes gloves between each client's specimens.

6. Contaminated gloves are not to be worn outside the clinical exam rooms or the laboratory.

7. Hands are to be washed before and after a change of gloves, and always before leaving the examination room.

8. Hands or other skin should be immediately and thoroughly washed if contaminated with blood or other bodily fluids. If any type of work exposure occurs, the employee follows the agency's protocol for exposure. This includes needlestick injuries, as well.

9. Infectious waste is contained in leak proof plastic bags, and bags are placed in the correct receptacle for incineration.

10. All employees to whom universal precautions apply are offered the Hepatitis B vaccination series, unless the employee can present legal documentation of previous Hepatitis B vaccination series of three injections. If the Hepatitis B vaccinations are given to the employee at the Division of Public Health Services, these are at no cost to the employee. If the employee declines to take the Hepatitis B vaccination series, the employee signs a waiver form, releasing the agency from any ill effects, regarding Hepatitis B, should the employee incur any health problems due to risk for exposure to this disease.

11. Transportation of specimens from treatment room to the lab:

    a. All specimens are properly labeled in the treatment room with client identifying information.
    b. The specimens are transported to the lab in a biohazard labeled tray.
    c. Wet mount specimens are covered with Parafilm.
    d. Urethral gram stain slides are placed in a clean plastic cup and covered with Parafilm.
    e. Specimens submitted to outside labs:
        - Are properly labeled with identifying information; and
        - Are sent in biohazard labeled containers.

J. Documentation:

1. Documentation will meet the Division of Public Health Services' medical records policy guidelines.

2. Completion of the following is essential:

    a. Client complaints.
    b. Abnormal findings described.
    c. Lab results documented.
    d. Diagnosis/impression.
    e. Treatment/management plan.
    f. Ensure client consents.

K. <u>Quality Assurance/Quality Improvement</u>:

1. State and local reports and statistics are reviewed at least annually to determine if the needs of the community are being met and changes made if indicated.

2. Clinical medical records are audited quarterly according to the department Quality Assurance Program Policy. These audits are scheduled and coordinated by the Staff Development Coordinator for the Division of Public Health Services. All staff within the Family Planning/STD Program will assist with the completion of

audits. Random STD medical records will be reviewed from each month of the quarter.

a. The purpose of the medical record audit will be to:

   1) Ensure that the level of medical care specified by the contract addendum, STD/HIV policies, procedures, and protocols of the specified programs are being met.
   2) Discuss problems in clinic and STD/HIV Program and make recommendations to correct deficiencies found, and other improvements.

b. The chart selection will be based on a computer printout of the program and quarter in review. The charts will be randomly selected from the printout. The current NC STD Public Health Program Manual audit forms will be used.

c. The results of the audit will be tabulated and recorded in summary. Information discussed within the report will have the client's medical record number, rather than any other identifying information.

d. All members of the program team will be informed of the results of the audit. The strengths and weaknesses will be identified and summarized along with a corrective plan of action.

3. Rockingham County DHHS- Division of Public Health Clinical services will distribute and monitor electronic client satisfaction surveys.

   a. Client Satisfaction Surveys are electronically distributed, per utilization of the Patagonia Electronic Health Record, monthly for all DHHS clinical programs including Sexually Transmitted Disease Program.

   b. Monthly survey results are analyzed by designated staff and a report of the findings will be generated and distributed to staff. Areas for improvement will be addressed to ensure customer satisfaction by staff utilization of knowledge obtained from surveys.

   c. Sexually Transmitted Disease client survey results provide input regarding client levels of satisfaction with the clinical services received. Survey results are evaluated to aid in determination in service adjustment as indicated.

   d. The results are also disseminated to the Board of Health and Human Services.

4. The STD Program monitoring site visits will be conducted by the CDB Regional Nurse Consultants. These periodic monitoring visits may include observation of clinic flow, laboratory, and clinical

practices, and a review of encounter data, policies and procedures, and client records. Client and employee satisfaction surveys, face-to-face client interviews and an administrative staff interview will also be conducted during site visits.

a. STD ERRN clinical practice may be evaluated with STD Program monitoring site visits. The STD ERRN must demonstrate satisfactory or better skills in each area of the assessment to maintain credentials as an STD ERRN who can be rostered. STD ERRN may not provide clinical assessments without a valid certificate. Certificates should be posted in the clinic where examinations are performed.

b. Remote monitoring of STD disease surveillance, investigation, treatment, and reporting will be conducted by a quarterly review of NC EDSS data, including reports, workflows, and disease events. The Division of Public Health Services should have a quality assurance measure that ensures medical record documentation and NC EDSS documentation is accurate and consistent with Agreement Addendum criteria.

c. The Division of Public Health Services may request assistance from the CDB Regional Nurse Consultant for quality improvement initiatives in the STD Program. The Division of Public Health Services may receive an annual profile of their STD clinical services prepared by the CDB Regional Nurse Consultant. This report will be based upon the most recent site visit report, the *STD Services Access/Availability Data, STD ERRN Annual Report of Continuing Education and Verification of Clinical Skills*, STD ERRN Clinical Assessment Tool reports and a review of the NC EDSS data.

d. The Division of Public Health Services must maintain compliance with all performance measures or be subject to a corrective action plan. If the corrective action plan is not followed and the Division of Public Health Services remains out of compliance, funds will be withheld and the Agreement Addendum may be terminated.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/ Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CLINICAL PROTOCOLS FOR STD CLIENT EXAM

DATE DEVELOPED: 4/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/22

I. POLICY:

The clinical staff of the Division of Public Health Services will provide STD screening for all clients requesting these services. The clinicians are skilled in collecting information in such a manner, as to provide a comfortable, non-judgmental setting, in which to obtain the client's reason for the clinic visit, and concerns that the client may express. The clinicians adhere to HIPAA regulations in maintaining the clients' confidentiality and in informing the clients regarding all of their rights, as stated in the HIPAA regulations. During the initial interview, the clinician establishes a good rapport with the client; shows respect, compassion, and a nonjudgmental attitude; ensures accurate definition of the problem(s); determines levels of risk for all STD's; and formulates a plan of care to meet the client's needs. For our Hispanic clients, an interpreter is part of the Family Planning/STD clinical team to facilitate this population's medical care not being compromised due to any language barriers. It is an important part of the interview process to explain to the client the reasoning behind asking very personal and intimate questions about the client's sexual history, in order to avoid receiving inaccurate information from the client, due to the sensitive nature of the questions. Without obtaining accurate information, this could delay or sidetrack an accurate diagnosis and compromise disease intervention efforts. Adolescents can consent to the confidential diagnosis and treatment of STD's. Medical care for STD's for adolescents can be provided without parental consent. Techniques that can be effective in facilitating rapport with the client include using open-ended questions, using understanding language, and reassuring the client that treatment will be provided, regardless of circumstances.

The forms that are used in the STD interview and screening are as follows:

1. "Sexually Transmitted Diseases," created by the N.C. DHHS, Office of Public Health Nursing, DHHS 2808; Office of Nursing and uploaded into the Division of Public Health Services Electronic Health Record (EHR).

2. State Laboratory forms:

    a. "Chlamydia/Gonorrhea Detection", DHHS 4011; Laboratory
    b. "Syphilis Screening Serology" (RPR/RPR Titer if RPR Reactive); DHHS 3446; Laboratory
    c. **"**Virology"; DHHS 3431; Laboratory
    d. "Special/Atypical Bacteriology"; DHHS 4121; Laboratory
    e. "HIV/HCV Testing Report Form", DHHS 1111; Laboratory

3. The Division of Public Health Services' Laboratory forms:

   - "Gonorrhea Testing/Wet Mount" (use green form)
   - Pregnancy Testing (use yellow form)

4. Contracted reference laboratory (Quest) form; i.e. for requesting HSV I/HSV II serology, urine NAAT Gonorrhea/Chlamydia testing, urine NAAT Trichomoniasis testing, Hepatitis C testing, and rapid HIV or Syphilis testing.

II. PURPOSE:

The physical exam will verify client's history; uncover problems that may not have been revealed in the history and allow the clinician to obtain specimens for laboratory evaluation. The physical exam is important in assessing for possible sexually transmitted disease (STD). All clients presenting with concerns or history suggestive of STD should have a general STD screening exam. All clients seen in STD Clinics will have HIV/Syphilis tests done as a routine part of their STD evaluation unless they decline testing. Because Hepatitis B virus frequently is sexually transmitted, Hepatitis B or the combination Hepatitis A & B vaccination is recommended per ACIP guidelines for all unvaccinated persons being evaluated for an STD. Also, all Family Planning clients seen for their yearly physical exam are routinely screened for Gonorrhea, Chlamydia, a wet prep, and HIV/Syphilis as indicated based on age and reported sexual risk history. The client may opt out for HIV testing. Women who have not had a documented Pap test per current PAP screening guidelines will be counseled on availability of Family Planning services and referred to Family Planning Program for well woman services or to other programs for which they may be eligible to obtain this service.

III. GUIDELINES:

A. The examiner should look for manifestations of STDs above as well as below the waist. It is important to remember that more than one infection may be present; more than one site may be infected; and infection may be present without any symptoms.

B. The examiner should develop a routine for proceeding through the exam so that he or she is efficient, at ease, and does not omit parts of the exam. Having a specific order and routine also facilitates comfort for the client by minimizing the need for movement.

C. Follow a routine for handling clean and contaminated items--- always mentally designate the clean hand (for handling supplies) and the contaminated hand (for touching the lesions, genitalia and contaminated items) and keep these consistent throughout the exam. In the case of the Physician Extender (PE), unless staffing shortages prevent, there is a clinic employee assisting the PE, as the PE examines the client and collects all needed specimens; therefore, the PE, in this case, may contaminate both

gloves due to the fact that the assistant is holding all STD specimen containers in which the PE places the collected specimens. The person assisting the PE also wears gloves, and transports all collected specimens to the laboratory in a biohazard-labeled, plastic, washable tray, to prevent spillage of collected specimens.

D. Before proceeding with the male exam:

1. Collect all necessary supplies in a location convenient to the exam process to facilitate efficiency and avoid contamination.
2. Have ready the appropriate lab requisition forms.
3. Label all slides, plates, and vials.
4. Provide instructions to client prior to performing skills.
5. Assess the client's understanding of the process and clarify his/her role.
6. Allow privacy for disrobing.

E. Supplies for Male Exam:

1. Routine Supplies:
   a. Gloves
   b. Penlight or flashlight or wall-mount otoscope/ ophthalmoscope
   c. Adjustable lamp
   d. Tongue depressor
   e. Sterile swabs
   f. Sterile calcium-alginate-tipped swabs (e.g., Calgiswabs) may be used if specimens are inoculated directly onto growth media
   g. Pen/Pencil to label slides and vials or client label
   h. State and local lab requisition forms as indicated
   i. Gonorrhea culture plates
   j. Glass slides

2. Optional Supplies:

   a. Urine specimen container
   b. Herpes culture transport media
   c. Sterile Dacron or Rayon-tipped swabs

F. Components of the Male Exam:

1. Observation of general appearance
2. Inspection of the upper body (both front and back)
3. Inspection of the skin and hair
4. Inspection of the oropharynx

5. Palpation of lymph nodes
6. Inspection of the genitalia
7. Rectal exam, when indicated

Note: Temperature should be recorded in clients presenting with a history of fever or who are acutely ill. The prostate exam is not indicated for STD screening.

G. Procedures for the Male Physical Exam:

1. As you proceed through the exam process, always:

   a. Include attention to the client's emotional and physical comfort.
   b. Explain to the client what you are doing and why, as well as what you find.
   c. Reassure when appropriate.
   d. Observe universal precautions with all clients.

2. Begin the exam with the client sitting upright on the table with shirt removed for upper body inspection, then follow with genital exam.

3. Upper body Procedures:

   a. Inspect the pharynx and oral mucosa with a light source for:
      1) Sores, pustules, or inflammation
      2) Lesions or patches suggestive of Syphilis, Herpes, or HIV that may be on gum lines, buccal mucosa, palate, and the top or bottom of the tongue.

   Note: Oral infections are among the most common clinical manifestations of HIV disease.

   b. Collect a specimen from the throat for Gonorrhea culture when the history includes oral sex within the last two months.

   Note: PCR is not sufficiently specific for Gonorrhea testing at the oral site and should not be used.

   c. Inspect the scalp, brows, and lashes for hair loss suggestive of Syphilis, nits associated with pubic lice.
   d. Palpate lymph nodes beginning with the cervical nodes in the neck area and moving to supraclavicular, axillary, and epitrochlear.
   e. Inspect the skin for rashes, discoloration, or lesions. Begin with the face, then arms, hands, chest, and back. Inspect the palms of the hands and the soles of the feet if Syphilis is suspected.
   f. Have client put shirt back on; prepare for the genital exam.

4. Genital Exam Procedures: The male exam proceeds more effectively with the male in a standing position, facing the examiner; however, the practitioner may use her/his professional discretion regarding how to position the client for the genital exam. Instruct the client to lower pants and underwear and sit or lean back against the exam table.

    a. Assure light source is appropriately positioned for adequate visualization.
    b. Palpate the groin nodes for swelling or tenderness.
    c. Inspect the skin and hair around the base of the penis for nits, lice, or lesions.
    d. Inspect the top and bottom of the penis, retracting the foreskin if present. Look for redness, sores, warts, or other lesions and discharge from the urethral opening.
    e. Inspect the skin of the scrotum for lesions or rashes, making sure to lift the posterior surface.
    f. Palpate the scrotal contents by gently compressing between thumb and first two fingers. Note any swelling, tenderness, and the shape and size of any mass as you palpate the testes and the spermatic cords. This is a good point in the exam to assess the client's understanding of the importance of self-testicular exam and how to do it.
    g. Any lesion compatible with Syphilis should be evaluated with a RPR serology specimen, sent to the State lab.
    h. Collect specimens for gram stain, Gonorrhea culture.
    i. Examine the rectum when the history includes rectal exposure or symptoms. Examine the perianal area, anus, buttocks, and skin folds for inflammation, rashes, sores, warts, or other lesions.

5. Specimen collection:

    a. To collect a specimen from the throat for Gonorrhea culture:
        1) Label culture plate with client's full name, date of birth, collection date, and specimen site (throat).
        2) With a sterile Dacron or Rayon swab, swab the back of the throat and tonsillar crypts.
        3) Roll the swab in a "Z" pattern on the culture plate so that all surfaces of the swab make contact with the plate. Dispose of the collection swab. Transport the culture plate to the laboratory.
        4) Laboratory staff cross streak the "Z" pattern using a sterile wire or disposable loop.

    Note: Best practice for cross-streaking is performed by a trained laboratorian in a laboratory setting.

5) Oral specimens must have a confirmation test if culture is positive.

b. To collect a urethral specimen for gram stain with visible penile discharge:
   1) Label a glass slide with the client's full name, date of birth, and collection date.
   2) Use sterile Dacron or Rayon swab to collect a sample of the discharge from the penis.
   3) Roll the swab along the glass slide.

c. To collect a specimen for gram stain with no visible discharge:
   1) Label a glass slide with the client's full name, date of birth, and collection date.
   2) Milk the penis from base to tip to express discharge. If discharge is expressed, collect as described in "b".
   3) If no discharge is expressed, insert tip of the calcium alginate-tipped swab (e.g., Calgiswab) 1-2 cm into the urethral opening. The swab may be moistened with non-bacteriostatic saline to reduce discomfort.
   4) Gently rotate for 3-5 seconds
   5) Roll the swab along the glass slide.

d. To collect a urethral specimen for Gonorrhea culture:
   1) Label a culture plate with the client's full name, date of birth, and collection date.
   2) Roll the same swab used for gram stain in "Z" pattern on the Gonorrhea culture plate ensuring that all surfaces of the swab make contact with the plate. Dispose of the collection swab. Transport the culture plate to the laboratory.
   3) Laboratory staff cross streak the "Z" pattern using a sterile wire or disposable loop.

   Note: Best practice for cross-streaking is performed by a trained laboratorian in a laboratory setting.

   *It is not necessary to collect individual swabs for urethral gram stain and culture. Gram stain should be prepared first and then inoculate the culture plate.

e. To collect a rectal specimen for Gonorrhea culture:
   1) Label a culture plate with the client's full name, date of birth, collection date and specimen site (rectal).
   2) Insert a sterile Dacron or Rayon swab 2-3 cm into the anal canal, pressing laterally to avoid fecal matter and rotate swab against the wall several times.
   3) Roll the swab in a "Z" pattern on culture plate ensuring that all surfaces of the swab make contact

with the plate. Dispose of the collection swab. Transport the culture plate to the laboratory.

4) Laboratory staff cross streak the "Z" pattern using a sterile wire or disposable loop.

Note: Best practice for cross-streaking is performed by a trained laboratorian in a laboratory setting.

5) If there is significant fecal matter on the swab, discard and collect another specimen, pressing laterally.

Note: Bring Gonorrhea culture plates to room temperature prior to use. Place culture plate in a CO2-enriched candle jar within 15 minutes of collection. (This is done by our lab staff; see Lab Protocols for incubator protocols).

f. To collect specimen for Herpes culture from vesicular or pustular lesions: Open the vesicle with an 18-gauge needle. Use a Dacron or Rayon-tipped swab to abrade the base of the lesion (this assures a good sample of cells and not just fluid). Place the swab in the viral transport media immediately and take to lab for refrigeration until transported (see Lab Protocols).

g. To collect specimen for herpes from a crusted lesion, remove the crust of the lesion with moistened gauze. Scrape the base of the lesion with a Dacron or Rayon-tipped swab. Avoid making the lesion bleed. Place the swab in the viral transport media immediately, and take to lab for refrigeration until transported.

Note: The stage of the herpetic lesion and the quality of the specimen taken from the lesion are critical to accuracy of results.

Herpes simplex Virus (HSV) is recovered most efficiently from vesicular lesions, and infrequently from crusted lesions. When collecting a herpes specimen, emphasis is on getting cells from the base of the lesion.

h. For Syphilis and HIV screening, specimen collection is performed by the lab staff, and samples are sent to the State lab for testing.

i. The RCDHHS-Division of Public Health will provide the option of Chlamydia/Gonorrhea urine NAAT testing to asymptomatic male clients (when there are no clinical findings on exam or complaints of urethral symptoms, but urethral exposure within the last 60 days) as well as to

symptomatic male clients (including men who present with a complaint of urethral discharge, dysuria or intrameatal itching during the interview and have clinical findings on exam) who do not meet the NCSLPH criteria for free NAAT testing. Clients not qualifying for free NAAT testing who choose this testing will be responsible for the contracted cost of the test at the time of clinical visit. Male clients will also be provided the option of Trichomoniasis urine NAAT testing as this testing is not offered by NCSLPH. Clients choosing this testing will be responsible for the contracted cost of the test at the time of the clinical visit. Asymptomatic male clients not choosing NAAT urine testing will receive standard bacterial gram stain/Gonorrhea culture testing. Symptomatic male clients will receive standard bacterial gram stain/Gonorrhea culture testing even if opting to self-pay for urine NAAT testing. Male clients will be instructed in self-collection of a urine specimen as per laboratory protocols for this testing.

6. Clinicians should assess the sexual risk for all male clients, which should include the sex of the clients' sex partners. MSM (Men who have Sex with Men), including those with HIV infection, should routinely undergo straightforward, nonjudgmental STD/HIV risk assessment, prevention and counseling to reduce the transmission of HIV and STDs. The following screening is recommended at least annually for sexually active MSM.

    a. HIV serology, if HIV negative or not previously tested.
    b. Syphilis serology.
    c. Urethral smear and gram stain; if negative for GC, and symptomatic, client is treated for NGU; if asymptomatic, Gonorrhea culture is planted for screening.
    d. Rectal Gonorrhea culture in men who have had receptive anal intercourse.
    e. Pharyngeal Gonorrhea culture in men who perform unprotected oral sex.
    f. Individuals with chronic liver disease, men who have sex with men (MSM), and injection drug users or persons with multiple sex partners, and any person who has been incarcerated or who is Hepatitis C or HIV positive seeking treatment for a STD are candidates for Hepatitis A vaccine. North Carolina presently offers Twinrix Hepatitis A and Hepatitis B combination vaccine for this population. (See ACIP guidelines.) Clients presenting to STD program for

screening found to be eligible for vaccinations are educated, counseled and referred to onsite immunization clinic for vaccination.

7. Symptomatic STDs in MSM

   a. Urethral discharge
   b. Dysuria
   c. Anorectal symptoms (pains, pruritis, discharge, and bleeding)
   d. Genital or anorectal ulcers
   e. Other mucocutaneous lesions
   f. Lymphadenopathy
   g. Skin rash

H. Before proceeding with the female exam:

1. Collect all necessary supplies in a location convenient to the exam process to facilitate efficiency and avoid contamination.
2. Have ready the appropriate lab requisition forms.
3. Label all plates, vials, and plastic cup (with a small amount of normal saline in cup) with the client's full name and date of birth or client label.
4. Provide instructions to client prior to performing skills.
5. Assess the client's understanding of the process and clarify roles.
6. Have the client empty her bladder. Collect urine for pregnancy test, or for urinalysis per Physician Extender order, if indicated.
7. Give drape; have client remove top as indicated and undress from the waist down.
8. Allow privacy for disrobing.

I. Supplies for Female Exam:

1. Routine Supplies:
   a. Gloves
   b. Penlight or flashlight or wall-mount otoscope/ ophthalmoscope
   c. Adjustable lamp
   d. Tongue depressor
   e. Sterile swabs: Cotton-tipped swabs for wet prep/Dacron or Rayon swabs for cultures
   f. Sterile gauze
   g. ½-lcc normal saline solution in plastic cup for wet prep
   h. Water soluble lubricating gel
   i. Gonorrhea culture plates

j. Chlamydia/Gonorrhea probe (Gen probe)
k. Special pen for labeling GC culture plates or client label
l. Drapes for torso and from waist down
m. Specula
n. State and local lab requisition forms as indicated
o. PH paper

2. Optional Supplies:
   a. Urine specimen container
   b. Herpes culture transport media
   c. Sterile Dacron or Rayon-tipped swabs

J. Components of the Female Exam:

1. Observation of general appearance
2. Inspection of the upper body both front and back
3. Inspection of hair and skin
4. Inspection of the oropharynx
5. Palpation of lymph nodes
6. Lower abdominal palpation
7. Inspection of the genitalia
8. Speculum exam
9. Bimanual exam
10. Rectal exam, when indicated

K. Procedures for Physical Female Exam:

1. As you proceed through the exam process always:

   a. Include attention to client's emotional and physical comfort
   b. Reassure when appropriate
   c. Explain to client what you are doing and why, as well as what you find
   d. Observe universal precautions with all clients
   e. Begin the exam with the client sitting upright on the table for upper body inspection
   f. Have her lie back for abdominal palpation
   g. Follow with genital exam

2. Upper Body Procedures:

   Inspect the pharynx and oral mucosa with light source for:

   a. Sores, pustules, or inflammation
   b. Lesions or patches suggestive of Syphilis, Herpes, or HIV that may be on gum lines, buccal mucosa, palate, and the top or bottom of the tongue

Note: Oral infections are among the most common clinical manifestations of HIV disease in individuals; also, oral lesions may be found with Syphilis.

c. Collect a specimen from the throat for a Gonorrhea culture when the history includes oral sex within the last two months.
d. Inspect the scalp, brows, and lashes.
e. Inspect the hair for loss, which may result from Syphilis; also, inspect for nits associated with pubic lice.
f. Palpate lymph nodes beginning with the cervical notes in the neck area and moving to supraclavicular, axillary, and epitrochlear.
g. Inspect the skin for rashes, discoloration, or lesions. Begin with the face, then arms, hands, chest, and back
h. Inspect the palms of hands and soles of feet as part of Syphilis screen

3. Abdominal Exam:

a. Have the client lie supine
b. Check for rebound tenderness by quickly releasing the abdominal hand when palpating the abdomen
c. Assist the client into the lithotomy position at the edge of the table, with feet in the foot holders

4. External Genital Exam:

a. Sit to examine the pelvic area
b. Assure light source is appropriately positioned for adequate visualization
c. Palpate the groin nodes for swelling or tenderness
d. Inspect the pubic hair and the skin for nits, lice, or lesions
e. Examine the vulva for redness, sores, warts, or other lesions
f. Inspect the clitoris, retracting the prepuce to look for hidden lesions or warts
g. Inspect the perineum, anus, intercrural folds, and buttocks for redness or lesions
h. Prior to speculum insertion:
    1) Check the urethral meatus and Skene's glands by milking the glands against the urethra. Using a sterile Dacron or Rayon swab, collect and culture any discharge for Gonorrhea and Chlamydia as indicated.
    2) Inspect the introitus by inserting one finger into the vagina and palpating the Bartholin glands on both sides, noting tenderness, swelling or discharge.

Using a sterile swab, collect and culture any discharge from Bartholin glands for Gonorrhea and Chlamydia as indicated.

5. Speculum Exam

   a. Warm and lubricate the speculum with warm water only. Other lubricants will interfere with quality of specimens to be collected.
   b. Insert the plastic, disposable speculum:
      1) Place two fingers just inside the introitus and gently press down toward the perineum while asking the client to relax her muscles.
      2) With the other hand, insert the speculum at a 45-degree angle downward.
      3) Aim toward the small of the back and maintain slight downward pressure at the introitus to avoid pressure on the sensitive anterior structures.
      4) Once the speculum is inside the vagina, remove fingers from anterior structures and rotate speculum blades into a horizontal position, while maintaining downward pressure.
      5) Slowly open the blades, maneuvering the speculum so that the cervix comes into view.
      6) Secure the speculum in place.
      7) Inspect the cervix and its os for discharge, ectopy bleeding, ulcers, cysts or other lesions.
      8) Note characteristics, amount, and color of any discharge from the cervix.
      9) Inspect the vaginal mucosa and note lesions and character, amount, and color of any discharge.
      10) Order of specimen collection – The order of specimen collection has been a source of confusion for many providers. Presently there are no definitive data available for specific guidance on this issue.

          a. The wet prep is collected using a non-bacteriostatic, sterile swab.
          b. Gonorrhea/Chlamydia testing is done using the vaginal swab from Gen-probe Kit (NAAT).
          c. PH specimen is collected from the lateral side of the vagina, not the vaginal pool, using a sterile cotton-tipped swab.

      11) The following is the order of specimen collection ordinarily:

a. Collect specimen of any vaginal discharge for a wet prep.
b. Collect specimen of vaginal discharge for Chlamydia/Gonorrhea probe
c. Collect specimen of vaginal discharge for PH.

12) Unlock and slowly remove speculum from the cervix, closing blades and maintain downward pressure. Inspect vaginal walls as blades exit the vagina. Dispose in biohazard trash receptacle.
13) Perform a rectal exam, when indicated, and collect specimen for Gonorrhea culture when history includes rectal exposure or symptoms.

6. Bimanual Exam:

a. Examiner should stand for the bimanual exam.
b. Explain the procedure and encourage the client to relax her abdominal muscles.
c. Lubricate index and middle fingers.
d. Gently palpate vaginal walls and the cervix to locate the position of the cervix.
e. Put one finger on each side of the cervix and move it from side to side, noting if the client has any discomfort, i.e., cervical motion tenderness.
f. Using the free hand, palpate the abdomen and palpate for the uterus while the vaginal hand locates the cervix and uterine walls. If possible, trap the uterus between the hands and define its shape, position, and consistency.
g. Examine the fallopian tubes, ovaries, and adnexal structures noting tenderness.
h. Place two fingers of the vaginal hand to one side of the cervix and press downward with the abdominal hand on the same side, noting tenderness, including rebound tenderness.
i. Slowly and gently draw your hands together, feeling for any abdominal masses.
j. Include the rectovaginal exam as part of the pelvic exam when PID is suspected – performed by the Physician Extender as indicated.
1) Change gloves prior to the rectovaginal exam, to avoid transferring any infection that may be present in the vagina to the rectum.
2) Gently insert the index finger into the vagina and the middle finger into the rectum.
3) Palpate the rectovaginal septum.

4) Using the abdominal hand; feel for any abnormal masses in the posterior uterus, adnexa, and posterior pelvis.

7. Specimen Collection:

a. To collect a specimen from the throat for Gonorrhea culture:

1) Label culture plate with client's full name, date of birth, collection date and specimen site (throat)
2) With a sterile Dacron or Rayon swab, swab the back of the throat and tonsillar crypts
3) Roll the swab in a Z pattern on the culture plate so that all surfaces of swab make contact with the plate and cross streak
4) Oral specimens must have a confirmatory test if culture is positive.

b. To collect specimen for Herpes culture from vesicular or pustular lesions:

Open the vesicle with an 18-gauge needle, or use the Dacron or Rayon-tipped swab to gently open the vesicle. Abrade the base of the lesion with the swab to assure a good sample of cells and not just the fluid.

Place the swab in the viral transport media, and take to lab staff for refrigeration until transporting.

c. To collect specimen for Herpes culture from crusted lesions:

Remove the crust of the lesion with moistened gauze. Scrape the base of the lesion with a Dacron or Rayon-tipped swab. Avoid making the lesion bleed. Place the swab in the viral transport media immediately, and take to lab for refrigeration until transporting.

Note: The state of the lesion and the quality of the specimen taken from the lesion are critical to accuracy of results. HSV is recovered most efficiently from vesicular lesions, and infrequently from crusted lesions. When collecting a Herpes specimen, emphasis is on getting cells from the base of the lesion.

d. To collect a wet mount specimen:

1) Label plastic cup with one of the client's pre-printed labels.
2) Use a non-bacteriostatic, sterile cotton-tipped swab.
3) Gently rotate the swab over the vaginal wall avoiding the cervicovaginal pool.

4) While avoiding cervical mucus and blood, dip pH paper in vaginal secretions from wall of the vagina, or touch it with the swab to obtain the pH.
5) Insert discharge-moistened swab into the plastic cup containing approximately 1ml of saline, cover cup with parafilm for transport to lab.
6) Transport plastic cup to lab, in biohazard-labeled, washable, plastic tray for microscopic examination.

Note: The wet prep specimen is collected from the vaginal fluid before specimens for Gonorrhea and Chlamydia are collected.

e. To collect the vaginal swab for Gonorrhea/Chlamydia testing with NAAT:
1) Partially peel open the swab package. Do not touch the soft tip or lay the swab down. If the soft tip is touched, the swab is laid down, or the swab is dropped, use a new APTIMA Vaginal Swab Specimen Collection Kit.
2) Remove the swab.
3) Hold the swab, placing thumb and forefinger in the middle of the swab shaft.
4) Carefully insert the swab into the vagina about 2 inches (5 cm) past the introitus and gently rotate the swab for 10 to 30 seconds. Make sure the swab touches the walls of the vagina so that moisture is absorbed by the swab.
5) Withdraw the swab without touching the skin.
6) While holding the swab in the same hand, unscrew the cap from the tube. Do not spill the contents of the tube. If the contents of the tube are spilled, use a new APTIMA Vaginal Swab Specimen Collection Kit.
7) Immediately place the swab into the transport tube so that the tip of the swab is visible below the tube label.
8) Carefully break the swab shaft at the score line against the side of the tube and discard the top portion of the swab shaft. Do not spill the contents of the tube. If the contents of the tube are spilled, use a new APTIMA Vaginal Swab Specimen Collection Kit.
9) Tightly screw the cap onto the tube.
10) Transport the specimens to the lab in a biohazard-labeled, washable, plastic tray for submission to NC SLPH or reference laboratory.

f. To collect a rectal specimen for Gonorrhea culture:

1) Label culture plate with client's full name, date of birth, collection date and specimen site (rectal).
2) Insert a sterile Dacron or Rayon swab 2-3 cm into anal canal, pressing laterally to avoid fecal matter and rotate swab against the wall several times.
3) Roll the swab in Z pattern on culture plate and cross streak.
4) If there is significant fecal matter on the swab, discard and collect another specimen pressing laterally.

L. Proper Condom Usage:

Clients should be advised that condoms must be used consistently and correctly to be highly effective in preventing STDs.

1. Use condoms made of latex rather than natural membrane.

2. Do not use torn condoms, those in damaged packages, or those with signs of age (brittle, sticky, discolored, past expiration date).

3. Put the condom on the penis before it touches a partner's mouth, vagina, or anus.

4. Put the condom on the penis when it is erect and before any genital contact. Make sure you have the rim side up so you can unroll it all the way down to the base of the penis, before the penis comes in contact with a body opening.

5. Leave a space at the tip of the condom to collect semen; remove air pockets in the space by pressing the air out towards the base.

6. Use only water-based lubricants, such as K-Y jelly, Astroglide, Aqualube, and Glycerin. Lubricants such as petroleum jelly, mineral oil, cold cream, vegetable oil, or other oils may damage the condom.

7. Use of Nonoxynol 9 inside the condom or inside the vagina does not increase protection against STDs and HIV infection. However, if spermicides cause local irritation, they may increase the risk of HIV infection. Nonoxynol 9 does not give added protection in anal intercourse.

8. Replace a broken condom immediately.

9. Hold the condom firmly against the base of the penis during withdrawal, and withdraw while the penis is still erect to prevent slippage.

10. Do not reuse condoms.

11. Use new condom with each act of sexual intercourse (oral, vaginal, anal).

12. Carefully handle the condom to avoid damaging it with fingernails, teeth, or other sharp objects.

13. Ensure adequate lubrication during intercourse, possibly requiring the use of exogenous lubricants.

M. Obtaining Test Results for all STD Clients:

1. Clients are advised of test results that are available on the day of the STD screen: these include the pregnancy test, if indicated, and wet mount, on female clients, and the urethral gram stain for WBCs/ Gonorrhea on the male clients. All lab services performed at the Division of Public Health Services will be consistent with CLIA Guidelines.

2. Clients seen for STD screening are advised that they will be notified of any/all abnormal test results when laboratory reports are obtained. Clients are requested to provide a reliable telephone contact number that they may be reached should test results require notification. Clients are not notified if all test results are normal/negative.

3. For clients desiring a verbal report of STD test results, the client may call the clinic in about 2 weeks and results may be given over the phone, but only after the client gives the STD Program staff the client's full name, correct Social Security number, and date of birth.

4. When the client has positive STD test results, the STD ERRN does the following after verification of client identity:

   a. Gives the client the name of the positive disease(s), information about the disease(s), verbally, as well as with educational materials (when teaching is provided face-to-face).
   b. Name of medications that are being prescribed/administered to treat the STD(s); for those medications that the Physician Extender (PE) applies, for example, genital warts, the PE informs the client regarding the use of the medication, contraindications, how the medication affects the genital warts, and how long the client is to leave the medication on the affected area prior to washing the medication off. For all medications that are prescribed and filled in the Division of Public Health Services' Pharmacy, the PE/STD ERRN/ Pharmacist reviews the name of the medications and how they are to be taken. In addition, the client receives a computer-generated print out, from the pharmacist,

informing the client about all aspects of the prescribed medication (see Pharmaceutical List/client handouts). The STD ERRN may treat client by Direct Observed Therapy (DOT) for Chlamydia, Gonorrhea, NGU, Trichomoniasis, Syphilis or contact to Syphilis, and MPC per standing orders.

c. Expected outcome of treatment.
d. Description of behaviors and conditions that will maximize efficiency and minimize side effects of treatment.
e. Any follow-up appointment, if needed.
f. Stress how re-infection can occur.
g. Counsel on the proper use of condoms.

4. Importance of evaluating sexual partners by making sure that client understands:

a. How the disease(s) is/are transmitted, incubation period.
b. Time of infectiveness.
c. Consequences to the health of the client and partner if not medically evaluated and treated.
d. Giving of appropriate cards for partner notification.
e. Necessity of abstaining from sex, of any form, until contact(s) has/have evaluation and treatment, as contact(s) to positive STD (s), and until completion of partner(s) treatment.
f. Clients testing positive for Chlamydia, Gonorrhea, NGU and Trichomoniasis should return to clinic in three months for re-evaluation/rescreen.

5. Prevention methods for females:

a. Female condoms: if used consistently and correctly, the female condom may substantially reduce the risk of STDs.
b. Vaginal spermicides, sponges, and diaphragms: Spermicides alone are not recommended for STD/HIV prevention. Neither vaginal sponges nor diaphragms should be relied on to protect women against STD/HIV infection.
c. Rectal use of N-9 Spermicides: N-9 should not be used as a microbicide or lubricant during anal intercourse.
d. Women who are at no risk for pregnancy should be counseled regarding the use of condoms and the risk for HIV/STDs.

N. <u>Medical Consultation and/or Referral:</u>

1. In instances where the PE identifies abnormal gynecological findings, which are complicated, medically, to the point of warranting a physician's evaluation, the PE refers these clients to the GYN medical consultants.

2. If the PE is not available on a particular day, the STD ERRN or the Supervisor/RN evaluates walk-ins, within their scope of practice, under the State Nursing Practice Act. These RNs may treat positive findings/diseases per standing orders, signed annually by the Division of Public Health Services Medical Director. Should the client have symptoms or clinical findings of an urgent nature (that cannot be safely postponed until the PE is in clinic), the RNs refer these clients, either to the Medical Director, urgent care, or the local ER, depending on the severity of the symptoms, and the availability of the Medical Director. In these urgent or emergency situations, the RNs call the health care providers to facilitate client management. All HIPAA guidelines are followed in any release of client information to outside resources.

3. Other client conditions which warrant physician referrals include:

    a. The diagnosis is uncertain, or disease is severe
    b. All positive HIV clients
    c. Testicles are painful, tender, or enlarged/irregular borders.

4. Serious sign of adverse reaction to treatment occurs, such as anaphylaxis; procaine reaction (seizures, psychosis, mania); distal paresthesia; fainting, other than vagus nerve response; or alterations in mental status.

5. Refer and consult according to local protocol.

6. The needed STD treatment or procedure is not specified in the standing orders.

7. A client with acute salpingitis is believed to need inpatient care.

8. A pregnant client who is just informed of positive pregnancy test or a client who is not receiving prenatal care.

9. Clients who desire sterilization.

10. Recurrent urinary tract infections.

11. Urethritis does not respond to medical therapy.

12. Other urologic and prostatic disorders are recognized.

13. A general surgical evaluation is needed for such findings as an inguinal hernia, hemorrhoids, testicular varicocele or atrophy, or extensive warts.

14. Positive Hepatitis B clients.

O. Processing STD Records:

1. With all clients who have any positive STD test results, the Communicable Disease Nurse, Administrative Assistant IV staff or other designated/trained staff will report data to the NC EDSS.

2. The medical records supervisor also notifies the regional STD Disease Infection Specialist (DIS) regarding positive STD clients who present with conditions requiring close contact tracing such as HIV and Syphilis.

3. All positive reportable STD results are entered into the North Carolina Electronic Disease Surveillance System, and periodic reports are generated by the Communicable Disease Nurse, showing a breakdown according to disease and numbers of positive cases.

4. All positive Syphilis and HIV cases are referred to the regional DIS for partner notification and for testing/treatment recommendations. Partner notification is the process of learning from persons with STDs about their sexual partners and helping to arrange for evaluation and treatment.

5. All positive Hepatitis B clients are referred to the Communicable Disease RN for investigation into possible source of infection, and to protect the public health of any individuals who may have been exposed by the individual with Hepatitis B.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PHARMACEUTICALS USED IN THE TREATMENT OF SEXUALLY TRANSMITTED DISEASES

DATE DEVELOPED: 1/03
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/22

I. POLICY:

The Division of Public Health Services shall provide diagnosis, testing, treatment, follow-up, and preventive services for Syphilis, Gonorrhea, Chlamydia, Nongonococcal Urethritis, Mucopurulent Cervicitis, Chancroid, Lymphogranuloma Venereum, and Granuloma Inguinale. These services shall be provided upon request and at no charge to the client. Privately insured clients requesting HIV/STD services may authorize billing of their insurance carrier; however, refusal to permit insurance billing shall not prevent the client from receiving services, including treatment. In addition, treatment for Trichomoniasis, symptomatic Bacterial Vaginosis (initial diagnosis), and symptomatic Herpes (initial diagnosis) will be provided since these conditions may contribute to HIV transmission. Conditions that are likely caused by Gonorrhea or Chlamydia, such as Pelvic Inflammatory Disease (PID) and Epididymitis, should also be treated. Acyclovir may be used as suppressive therapy for Herpes simplex virus (HSV) infection (initial diagnosis), without cost to the uninsured client, for the first four months of therapy. Subsequent doses may be provided to the client for a fee as per local policy. The Division of Public Health Services may not use state funds for scabies infections or candidiasis. State funds designated for purchase of STD drugs are to be used exclusively for the treatment of local health department clients who are either diagnosed with or who are sexual partners of someone with a STD.

The RCDHHS-Division of Public Health Services will offer onsite STD treatment from appropriately trained staff to any person diagnosed with an STD and sexual partners of a person with an STD who is evaluated by the LHD. Onsite STD treatment is defined as administering approved drug treatment regimens at the time of diagnosis or providing client with a prescription for an approved drug treatment regimen.

II. PURPOSE:

The management of clients with a sexually transmitted infection diagnosed in the STD Program clinic is based on the current guidelines of the North Carolina Sexually Transmitted Diseases Public Health Program-Centers for Disease Control and Prevention Division of Sexually Transmitted Diseases Prevention following the current NC-CDB STD Treatment Guide for Adults and Adolescents and is consistent with North Carolina General Statute 130A-144 and Communicable

Disease Rules 10A NCAC 41A .0101, .0102, .0202, and .0204. The Division of Public Health Services utilizes allocated state funding to purchase STD Program drugs at the lowest available pricing through the Health Resources and Services Administration's (HRSA) federal 340-B Drug Pricing Program stretching federal and state resources as far as possible thereby reaching more eligible clients and providing more comprehensive services. The goal is to reduce the morbidity, mortality and spread of STD's in Rockingham County, surrounding counties and North Carolina.

III. GUIDELINES:

A. Treatment protocols which list more than one option for treatment must be adapted to list ONE treatment for RN/STD ERRNs practicing under standing orders so the RN/STD ERRN does not have to make a choice. Specific circumstances for using an alternative treatment need to be clearly defined. This supports the need for consultation with physician or midlevel provider when choices must be made.

B. Pharmaceuticals used in the treatment of sexually transmitted diseases:

1. Acyclovir* (county supply also available)
2. Valacyclovir*
3. Amoxicillin*
4. Azithromycin*
5. Benzathine Penicillin G*
6. Ceftriaxone*
7. Doxycycline* (county supply also available)
8. Metronidazole* (county supply also available)
9. Tinidazole*
10. Cefixime*
11. Clindamycin oral tablets/Clindamycin 2% vaginal cream*
12. Metronidazole gel or Metrogel
13. Permethrin (Nix or Elimite)
14. RID – available over the counter
15. Trichloroacetate (TCA)*
16. Levofloxacin*
17. Imiquimod*
18. Gentamicin*
19. Fluconazole
20. Moxifloxacin*

Included in this section are the client medication handouts, generated by the pharmacy computer, when the Division of Public Health Services' pharmacist fills a prescription. The pharmacist, RN, or ERRN verbally reviews all instructions regarding how to take the prescription, and reviews

the medication information handout sheets. The client is given the handout sheets to take home with them for reference.

Medications with an asterisk (*) by the drug are provided by state 340-B funding. These drugs: Azithromycin, Ceftriaxone, Benzathine Penicillin G, Cefixime, Gentamicin, Metronidazole 2 gm PO in a single dose or Tinidazole 2 gm PO in a single dose are administered by directly observed therapy in the STD clinical setting. Trichloracetic acid is administered by the Physician Extender in the STD/Adult Health clinical setting.

The clinicians inform the client, prior to the administration of these medications, regarding the use of the medication, potential side effects, and follow-up guidelines related to each of these medications. (See client pharmacy computer-generated handouts on all other medications used.)

IV. REFERENCES:

North Carolina Administrative Code (10A NCAC 41A.0204)

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/ Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: CHLAMYDIA PROTOCOLS

DATE DEVELOPED: 5/96
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/22

I. POLICY:

The clinical staff of the Division of Public Health Services will assess and/or evaluate clients for Chlamydia Trachomatis. Chlamydia Trachomatis is a bacterial intracellular parasite that causes a wide range of infections. In the United States, Chlamydia Trachomatis is the most prevalent of all STDs and since 1994 has comprised the largest proportion of all STDs reported to CDC. Chlamydial infections in women are usually asymptomatic. However, untreated infection can result in Pelvic Inflammatory Disease (PID) which is a major cause of infertility, ectopic pregnancy and chronic pelvic pain. Chlamydia Trachomatis is spread by having unprotected vaginal, oral or anal sex with someone who has Chlamydia Trachomatis. Reinfection may occur even if treated in the past and Chlamydia Trachomatis infection during pregnancy can be passed to the fetus resulting in complications.

II. PURPOSE:

The STD Program clinical staff of the Division of Public Health Services will screen and treat clients presenting with symptoms and/or as a contact to Chlamydia Trachomatis based on the current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program – Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP).

III. GUIDELINES:

A. HISTORY: Chlamydial Trachomatis is frequently asymptomatic; however, a purulent discharge may be found. Dysuria and frequency (urethral syndrome) may be present. A history of Non-gonococcal urethritis in the male partner is associated with a high incidence of isolation of Chlamydia from the female partner.

B. PHYSICAL EXAMINATION: Although the cervix may appear normal, there is often a significant increase in the incidence of cervical ectopy, erythema, and friability, as well as the presence of mucopus readily seen on a cotton-tipped swab. Mucopurulent cervicitis is often caused by Chlamydia infection.

C. INVESTIGATIVE PROCEDURES**:** Nucleic Acid Amplification Testing is a reliable way to establish the diagnosis. (See "Clinical Protocols for STD Client Exam" for procedure of collection and processing of specimen for Chlamydia testing STD-2.)

D. MANAGEMENT**:** Treatment of uncomplicated urethral, endocervical, or rectal Chlamydia Trachomatis infections is the following: Doxycycline 100 mg PO BID x 7 days.

E. RETEST: Clients who have been treated for positive Chlamydia should be retested three months after treatment, due to high risk for reinfection.

F. TREATMENT OF CHLAMYDIA TRACHOMATIS IN PREGNANCY: It is the standard of practice at the Division of Public Health Services to refer all pregnant clients to the client's established OBGYN provider; however, if the situation arises in which our clinic staff diagnose positive Chlamydia in a pregnant woman, recommended treatment for pregnant or assumed pregnant clients is Azithromycin 1 gm PO x one (1) single dose (Doxycycline is contraindicated in pregnancy).

G. SEX PARTNERS OF CLIENTS WITH CHLAMYDIA TRACHOMATIS INFECTIONS**:** Sex partners of clients who have positive Chlamydia Trachomatis infections should have a STD screen, and be treated as a sexual contact to a laboratory confirmed case of Chlamydia if their sexual contact was within 60 days or the sex partner is the last known sex partner of the client who has a positive Chlamydia Trachomatis infection. Recommended treatment for nonpregnant clients is Doxycycline 100 mg PO BID x 7 days. If allergic to Doxycycline, recommended treatment is Azithromycin 1 gm PO x one (1) single dose.

H. OTHER MEDICATIONS THAT MAY BE PRESCRIBED, IF THE CLIENT IS NOT PREGNANT:

Note: Any alternative treatment not specified by standing order requires evaluation by the Physician Extender and orders for such treatment.

Levofloxacin 500 mg PO QD x 7 days

I. OTHER MEDICATIONS THAT MAY BE PRESCRIBED, IF THE CLIENT IS PREGANT:

Note: Any alternative treatment not specified by standing order requires evaluation by the Physician Extender and orders for such treatment.

Amoxicillin 500 mg PO TID x 7 days

J. Azithromycin continues as primary treatment for Chlamydia in pregnant women with Amoxicillin 500 mg orally three times a day for 7 days as an alternative treatment if the pregnant client is allergic to Azithromycin.

K. Counseling/Instructions to Client:

1. Abstain from sexual intercourse for seven days after a one (1) time single dose treatment or until 7 days after completion of 7-day medication regimen.
2. Abstain from sexual contact until client and sexual partner(s) have completed medication and recommended abstinence time.
3. Correct condom use, including client-specific counseling and literature about personal risk reduction behavior.
4. Caution female clients taking oral contraceptives to use back-up method for birth control while on antibiotic(s) therapy and for 7 days after completion. (Client should not be sexually active until medication is completed and recommended abstinence time.)
5. Caution clients not to become pregnant while taking Doxycycline.
6. Counsel clients regarding the importance of early re-evaluation if symptoms persist or recur.
7. Counsel clients about risk of HIV infection and recommend HIV testing.
8. If abdominal pain or fever develops, call the clinic at the Division of Public Health Services. This is very important if the client has an IUD.
9. If the client is using a diaphragm, it needs to be disinfected by cleaning with per manufacturer's instructions.
10. Counsel client on necessity of partner(s) notification in order to prevent further spread of the disease. Give the client the appropriate number of Partner Cards needed to give to all sexual contacts within the last 60 days or last known sexual partner if most recent partner was greater than 60 days.
11. Clean shared sex toys, if applicable, and educate client on how to prevent transmission of infections by cleaning and covering shared sex toys per manufacturer's instructions in the future.
12. Women who are pregnant should not be treated with quinolones or tetracyclines (Doxycycline; Levofloxacin, Ciprofloxacin).

L. Follow-up:

1. Positive Chlamydia Trachomatis test results/events are reported to the state through the North Carolina Electronic Disease Surveillance System (NC EDSS); this is done by the Communicable Disease Coordinator or other designated/trained staff.

2. Clients whose symptoms persist, worsen, or reappear after treatment should return to the Division of Public Health Services' STD clinic for re-evaluation.
3. Clients treated for positive Chlamydia should be retested three months after treatment due to high risk for reinfection rates.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: GENITAL HERPES PROTOCOLS

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/22

I. POLICY:

The Family Planning/STD Program Physician Extender of the Division of Public Health Services will evaluate, provide diagnosis and treatment plan for clients with symptoms of Genital Herpes presenting for STD screening/services.

A. Definition: Herpes simplex progenitalis appears as a primary and recurrent problem in sexually active persons.

B. Etiology: Two similar but antigenically different strains of Herpes virus hominus:

1. Type 1 usually affects skin and mucous membranes above the umbilicus.
2. Type 2 usually affects skin and mucous membranes below the umbilicus. After the primary infection, the virus remains latent in nerve cells that are in the area of the original lesions. (This is true of both types 1 and 2)

Note: The difference in distribution between types 1 and 2 has become less distinct in recent years.

II. PURPOSE:

The Physician Extender of the Division of Public Health Services will evaluate, diagnose and treat clients for genital herpes based on the current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program – Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP). Detection, counseling/ education and care for sexually transmitted infections that pose a significant threat to the public improve the health of people in Rockingham County and North Carolina. These efforts aid the reduction of morbidity and mortality resulting from communicable diseases.

III. GUIDELINES:

A. Type 2/Genital Herpes:

1. Primary infection:

a. Symptoms:

1) Incubation period of 3-7 days
2) Mild to severe discomfort
3) Sometimes, prodrome of mild parasthesia or burning
4) Later, continuous vulval or penile pain, which may be severe
5) Dysuria and, occasionally, urinary retention
6) Tenderness of infected area
7) Sometimes, dyspareunia
8) Fever, headache, malaise
9) Course of 2-4 weeks

b. Signs:

1) A cluster of blisters or round erosions in the genital area (the most common clinical picture at the time the client seeks medical attention)
2) Indurated papules or vesicles surrounded by erythema, which often coalesce to form large ulcers.
3) Lesions located on vulva, genitocrural folds, perianal skin, vaginal and cervical mucosa in females, and urethral meatus and penis in males.
4) Maceration in moist areas
5) With extensive involvement, edema is present
6) Inguinal lymphadenopathy
7) Sometimes, urethral discharge in males

2. Recurrent Infections:

a. Symptoms:

1) Symptoms are similar to those of the primary infection but usually less severe. Prodromal symptoms are usually present.
2) Reactivation of the latent virus may be related to fever, premenstrual tension, vigorous sexual activity, and direct sunlight.

b. Signs:

1) Lesions are found in the same location as the primary infection.
2) Signs tend to be less severe than those of primary infection.
3) Early lesions are vesicles that rupture and tend to ulcerate.

B. Laboratory Studies: Diagnosis is usually made on the basis of clinical syndrome, but specific viral cultures are done to confirm the diagnosis. (See STD-2 "Clinical Protocols for STD Client Exam".)

- Clients presenting with genital ulcers should have evaluation with serology for Syphilis/HIV and culture for Herpes simplex virus (HSV).

C. Management/Treatment:

1. First Clinical Episode of Genital Herpes:

   a. Acyclovir 400 mg PO TID x 7-10 days, or
   b. Famciclovir 250 mg PO TID x 7-10 days, or
   c. Valacyclovir 1 gm PO BID x 7-10 days

2. Episodic therapy for recurrent Genital Herpes:

   a. Acyclovir 800 mg PO BID x 5 days, or
   b. Acyclovir 800 mg PO TID x 2 days, or
   c. Famciclovir 125 mg PO BID x 5 days, or
   d. Famciclovir 500 mg orally once, followed by 250 mg BID x 2 days, or
   e. Famciclovir 1000 mg PO BID x 1 day, or
   f. Valacyclovir 500 mg PO BID 3 days, or
   g. Valacyclovir 1 gm PO daily x 5 days

3. Daily Suppressive Therapy for recurrent Genital Herpes:

   a. Acyclovir 400 mg PO BID, or
   b. Famciclovir 250 mg PO BID, or
   c. Valacyclovir 500 mg PO QD, or
   d. Valacyclovir 1 gm PO QD

4. Episodic therapy for HIV infected clients:

   a. Acyclovir 400 mg PO TID x 5-10 days, or
   b. Famciclovir 500 mg PO BID x 5-10 days, or
   c. Valacyclovir 1 gm PO BID x 5-10 days

5. Daily Suppressive Therapy for HIV Clients

   a. Acyclovir 400-800 mg PO BID, or
   b. Acyclovir 400-800 mg TID, or
   c. Famciclovir 500 mg PO BID, or
   d. Valacyclovir 500 mg PO BID

6. Acyclovir may be used as suppressive therapy for initial HSV infection without cost to the client for the first 4 prescriptions/

regimens of therapy to allow the client adequate time to establish primary care. Clients diagnosed with Genital Herpes (HSV II) will receive counseling, education and be provided information on local resources for continuation of care for management of this health condition. If the client's HSV II is managed in the Adult Primary Care program at RCDHHS-Division of Public Health Services, subsequent medication therapy may be provided to the client for a fee as per local policy. Clients will be given an in-house medication order and directed to the in-house pharmacy to purchase oral county supplied Acyclovir. Acyclovir prescribed for suppressive HSV II therapy is not purchased with 340-B funds. It is provided at a low cost for the convenience of our clients via local county funding.

D. Specific counseling messages should include the following information.

1. Clients who have genital herpes should be educated about the natural history of the disease, with emphasis on the potential for recurrent episodes, asymptomatic viral shedding, and risks of sexual transmission.

2. Clients experiencing a first episode of genital herpes should be advised that suppressive and episodic antiviral therapy is available and is effective in preventing or shortening the duration of recurrent episodes.

3. All persons with genital HSV infection should be encouraged to inform their current sex partners that they have genital herpes and to inform future partners before initiating a sexual relationship.

4. Persons with genital herpes should be informed that sexual transmission of HSV can occur during asymptomatic periods. Asymptomatic viral shedding is more frequent in genital HSV-2 infection than genital HSV-1 infection and is most frequent in the first 12 months of acquiring HSV-2.

5. Clients should be advised to abstain from sexual activity with uninfected partners when lesions or prodromal symptoms are present.

6. Latex condoms, when used consistently and correctly, can reduce the risk for genital herpes when the infected areas are covered or protected by the condom.

7. Sex partners of infected persons should be advised that they might be infected even if they have no symptoms.

E. Follow-up:

Clients diagnosed with genital herpes (HSV 2) are advised to establish care with a primary provider to establish an on-going treatment plan. Upon request, clients are provided with community resources for care including follow-up at the Division of Public Health Services Adult Primary Care Clinic. Clients whose symptoms persist, worsen, or reappear after treatment may return to the Division of Public Health Services STD clinic for re-evaluation under Adult primary Care Clinic guidelines.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: HIV SERVICES AND PROTOCOLS

DATE DEVELOPED: 5/94
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/22

I. POLICY:

The professional staff of the Division of Public Health Services' Family Planning/ STD Program will recommend and offer HIV testing to all clients who seek evaluation and treatment for STDs. All clients seen in STD clinics will have a HIV test done as a routine part of their STD evaluation unless the client declines testing. HIV testing services are free of charge regardless of the client's county of residence. Qualified staff will be available to conduct on site STD evaluations/ assessments, and to provide treatment including injections, with standing orders for RN/STD ERRNs. All health department staff providing positive HIV test results to clients must attend the CD Branch-sponsored HIV-CTR training.

Minimal Counseling Standards – requirements per 10A NCAC 41A .0202 counseling for HIV testing shall include risk assessment, risk reduction guidelines, referrals for medical and psychosocial services, and when the person tested is found to be infected with HIV, control measures. Pre-test counseling is done individually to assure each individual is provided the opportunity to ask questions privately. Post-test counseling must be individualized.

Optimal Counseling Standards – clients who are high risk for HIV exposure receive client-centered HIV prevention counseling.

Client-centered – a type of counseling that is tailored to the behavior, circumstances, and special needs of the individual. The focus is on personal risk assessment and development of a personalized action plan.

HIV Prevention Counseling – a client-centered dialogue designed to support any client in making behavior changes that will reduce his/her risk of acquiring or transmitting HIV. The Division of Public Health Services provide client centered counseling based on the state-approved Counseling, Testing and Referral (CTR) training curriculum to clients who are HIV positive and to any other client who requests this service.

The Division of Public Health Services will ensure the STD Enhanced Role training course is completed by all nurses who provide clinical assessment and management of clients with STD concerns and that up-to-date standing orders and protocols are signed and available to guide practice. The Division of Public Health

Services will maintain a roster documenting the assessment and management of at least 50 STD clients per year of clinical practice and 10 hours of continuing education annually for STD Enhanced Role RNs. Documentation will include date of certification for the STD Enhanced Role, number of clients for STD assessment and management, and number of continuing education contact hours.

II. PURPOSE:

To control the spread of HIV infection among the population of Rockingham County by screening all clients requesting these services; by the clinician's assessment of a client's risk factors, indicating the need for HIV screening based on information given by the client to the interviewing professional; and as a routine part of the Family Planning annual preventive exam/other clinical exam as indicated by sexual health history and risk factors. The purpose is to protect the client's health by diagnosing HIV infection and referral for treatment as well as early detection of HIV infection to reduce the risk behavior that resulted in HIV infection and could result in transmission of HIV to others.

III. GUIDELINES:

A. Program/Medical Services: The Division of Public Health Services will perform services as outlined below and in accordance with the current guidelines for HIV Counseling, Testing and Referral. Effective HIV counseling, testing, and referral is based on the following principles:

- Protect confidentiality of clients who are recommended or receive HIV-CTR services.
- Clients should be notified that testing will be performed but given the option to decline or defer testing. Assent is inferred unless the client verbally declines testing.
- All testing is confidential.
- Provide information regarding the HIV test to all clients who are recommended for the test and to all who receive the test, regardless of whether prevention counseling is provided. Information should include the description of ways HIV is transmitted; importance of obtaining test results; and the meaning of the test results.
- Adhere to local, State, and Federal regulations and policies that govern provision of HIV services.
- Provide services that are responsive to client and community needs and priorities.
- Provide services that are appropriate to the client's culture, language, sex, sexual orientation, age, and developmental level.
- Ensure high quality services.
- Clients recommended for HIV counseling, testing, and referral:
    1) Client populations who are at risk for HIV exposure due to high risk sexual health behaviors.

2) Individual clients who have:
   a. Clinical signs and symptoms suggesting HIV infection.
   b. Diagnoses suggesting increased risk for HIV infection.
   c. Self-reported HIV risks.
   d. Specific request for an HIV test.
3) Regardless of setting prevalence or behavioral or clinical risk:
   a. All pregnant women shall be offered HIV testing by her attending physician at her first prenatal visit and in the third trimester. At the time HIV testing is offered and after informed consent is obtained, the attending physician shall test the pregnant woman for HIV infection unless the pregnant woman refuses the HIV test. If the HIV status of a pregnant woman is unknown at labor and delivery, the woman shall be tested for HIV. The Division of Public Health Services does not provide prenatal care. Pregnant clients established with a prenatal provider are advised to follow-up with their provider. Pregnant clients not established with a prenatal provider will be referred for services per client request.
   b. All clients with possible acute occupational exposure.
   c. Men who have sex with men.
   d. All clients seeking routine screening for STDs.
   e. All clients with known sexual or needle-sharing exposure to an HIV infected person.

- All clients who are recommended or who request HIV test should receive the following information, even if test is declined:
  1) Information regarding the test and its' benefits and consequences.
  2) Risks for transmission and how HIV can be prevented.
  3) The importance of obtaining test results and explicit procedures for doing so.
  4) The meaning of the test results in understandable language.
  5) Where to obtain further information.
  6) Where to obtain other services. (referral)

B. 1. HIV Risk Assessment and Prevention Counseling: Healthcare providers should be knowledgeable about symptoms and signs of acute retroviral syndrome (fever, malaise, lymphadenopathy, and skin rash), which frequently occur, in the first few weeks after HIV infection (before antibody test results become positive).

a. Client-centered counseling:
   1) To assess client's understanding of HIV infection and fill in gaps in HIV information.
   2) Client's risk factors.
   3) What protective measures client has currently adopted.
   4) Client's willingness to change to safer behaviors
   5) Negotiate realistic plan for risk reduction and review all risk reduction measures.

b. Discuss testing information:
   1) What negative/positive test results mean
   2) Risk factors that require testing
   3) Confidentiality/HIPAA guidelines followed
   4) Provide/review available HIV Testing Counseling pamphlets/education information.

c. Address client's concerns:
   1) Discuss plan to cope with waiting period
   2) Available support systems
   3) Advise client of protocol for test results/reports

d. Documentation of HIV Risk Assessment and Prevention Counseling:
   1) Physician Extender or STD ERRN notes recorded in the client's medical record.
   2) Division of Public Health protocol of no client notification of normal/negative test results.
   3) Clients advised of STD Program policy on obtaining test results for all STD clients (see STD-2 Clinical Protocols for STD Client Exam).

2. HIV Testing (Confidential):

a. Forms needed by clinic staff:
   1) HIV/HCV Testing Report Form DHHS 1111
   2) Electronic Health Record Sexually Transmitted Disease Screening form.
   3) Available HIV Testing and Counseling pamphlets/educational information.

b. Record in HIV Log Book, the client's identifying information/affix a medical record label, matching the DHHS form 1111 assigned form number, the HIV Log Book number, and log the date of testing.

c. A printed label with client's identification information may be used on HIV Testing Report form. If client's ID label is not available, this information is to be handwritten on the HIV Testing Report Form. The Division of Public Health Services only performs confidential testing.

d. Provide HIV risk assessment and counseling.
e. Complete HIV Testing Form to be sent to the state lab.
f. Refer client to lab for testing.
g. Client-centered counseling based on the state Counseling, Testing, and Referral (CTR) Curriculum must remain available for clients who are HIV positive or for any other client who requests this service. The health department will have at least two people trained at all times to meet client needs.

NOTE: In accordance with CDC and Branch strategies to assure clients know their HIV serostatus, the test decision model of counseling is waived for the purpose of testing. In the HIV testing process, the LPN can complete a risk assessment form and provide scripted education regarding the HIV test.

In accordance with 21 NCAC 36 .0225 (b), the LPN who has received HIV CTR training cannot counsel to help the client develop an individualized risk reduction plan based on risks but can provide scripted education regarding risk reduction.

3. Notification of HIV Results and Prevention Counseling: The client returns to clinic, by appointment, three weeks after testing if service requested.

a. Counseling regarding negative HIV test results:
1) Give negative HIV test results.
2) Review initial prevention counseling, as documented in the client's STD screening medical record.
3) Discuss meaning of negative test results and circumstances that require further testing. Address client's concerns.
4) Review client's risk factors.
5) Develop risk reduction plans with client.
6) Discuss specific behavioral changes that client could initiate to reduce risk.
7) Make referrals, as indicated, for mental health counseling, substance abuse services, and/or medical services.
8) Document post-test counseling.
9) The CDC recommends retesting three months from the date of exposure for persons who are at risk and have a negative HIV test. Individuals should be informed that 95% of individuals will have a positive test by three months after infection. If a test is done at three months, a second test at the six- month point should be considered.

b. Counseling regarding Indeterminate Test Results:
   1) Explain to client that test result is inconclusive and what that means.
   2) Explain to client regarding the need for retesting in 6 weeks from the date of current test.
   3) Explain to client the need to use same risk reduction precautions as person who tests HIV positive, until HIV status can be determined.
   4) Discuss client concerns/anxieties in dealing with indeterminate test results, offer client support, and refer client to Mental Health resources, if indicated, or requested by client.
   5) Repeat test results:
      a. If test results are negative, refer to section on counseling clients with negative HIV test results.
      b. If test results are positive, refer to section on counseling clients with positive HIV test results.
      c. If test results are indeterminate, refer clients to DIS for follow-up, and for evaluation by an infectious disease specialist or private physician.

c. Counseling Regarding Positive HIV Test Results:
   1) The Division of Public Health will report all sero positive HIV tests to regional DIS office within 24 hours of receipt of the positive report.
   2) The usual practice at the Division of Public Health Services is to pre-arrange for a DIS to be present at the time of the client's scheduled return visit; the DIS gives the client the positive HIV test result and the DIS assumes continual case management referrals and all other needed referrals for the positive HIV clients. If the HIV positive client does not return for post-test counseling, he/she will be referred to a Disease Intervention Specialist (DIS) for post-test counseling within 7 days.
   3) The DIS covers the following:
      a. Confirms the client's test number and identifying information with the test number.
      b. Advises client of positive HIV antibody test results.
      c. Explains what positive HIV test results mean.
      d. Define HIV/AIDS.

e. Assess client's emotional state; allows the client time to react to the positive test result.

f. Give additional information:
- Benefits of early medical intervention, current medical advancements/ medications that are impacting life expectancy.
- Advise client that he/she can transmit the virus to others and must use risk reduction precautions as recommended.
- Explain how healthy behaviors, such as healthy diet, decreased stress, adequate sleep, avoiding drugs/ETOH, can impact the quality of life.

g. Assess the client's understanding of information shared about HIV.

h. Assess client concerns and assess client's support system; who client could tell about his/her positive HIV status.

i. Explain that the Division of Public Health Services has to report the positive HIV test results to the State, but does not report to family, employer, etc.

j. If DIS not involved already at this point, inform the client that a DIS will take over management and follow-up of positive HIV client's case.

k. Review North Carolina Disease Control Measures for HIV infection and penalties of control measure violation.

l. A copy of the Disease Control Measures for HIV infection is provided to the client.

m. Stress condom use and offer/provide condoms.

n. Explain need for TB skin testing, administer IPPD, and schedule return appointment for 48-72 hours later for reading.

o. Discuss with client how he/she plans to cope the next few days. Give client number of mental health resources, or if the client is extremely upset, walk the client to the mental health clinic for an emergency session with one of the counselors.

p. Make any other referrals necessary to meet the client's needs (see resources).

q. Refer to Cone Health Home Care Providers at Alamance Regional HIV Medical Case Management for Alamance, Caswell and Rockingham Counties
3025 South Church Street, PO Box 202
Burlington, NC 27215
PH**:** **(**336) 538-8557
Reinforce AIDS HOT LINE numbers
North Carolina- (919) 361-8488

r. National-1(800)232-4636

s. If the Division of Public Health Services is unable to locate an HIV positive individual for post-test counseling, call the HIV/STD Regional DIS Supervisor to arrange for assistance with locating and post-test counseling the individual.

C. Laboratory Services: (refer to the Division of Public Health Services' laboratory policies and protocols)

1. CD4 testing is not available at the Division of Public Health lab.
2. The blood specimens drawn in our lab are sent to the State Lab for testing for presence or absence of HIV-1 P24 antigen and HIV antibody, accompanied by the appropriate lab forms.
3. Confidential laboratory testing is provided for at the Division of Public Health Services.
4. Verification of client identity is provided prior to drawing the blood for specimen.
5. Expedited (Fast Tracked) HIV Testing when clients present with conditions and histories compatible with acute HIV infections (see lab policy for procedure and criteria).

D. Issuance of Isolation Order:

All HIV positive clients are counseled by either a DIS or by a public health RN who has successfully completed the state-approved Counseling, Testing and Referral (CTR) training curriculum course.

1. All control measures are reviewed, as outlined in G.S. 130A-144 and initiated per the "Disease Control Measures for HIV Infection" form.
2. DIS is responsible for follow-up in partner notification.

E. Health Education:

1. Should be tailored to meet the client's/community's needs.

2. Carried out by counseling staff in clinical setting and by Health Educators from the Division of Public Health Services in the community.

F. Follow-up on positive HIV test results, reported to health department by outside agencies, hospitals, etc.:

1. The usual manner in which the Division of Public Health Services is notified about positive HIV cases, which were not tested at our health department, is by a State DIS calling the Communicable Disease Coordinator or designated staff, giving all information on the HIV positive client.
2. Should another medical resource call in positive HIV test results to the Division of Public Health Services, the Communicable Disease Coordinator or designated staff calls the State DIS worker to come to our health department and take over management of these cases.
3. HIV infected clients should have follow-up including RPR serologic testing at 3, 6, 9, 12, and 24 months, if reactive. If RPR serologic testing reactive, then a fourfold decline in the titer is expected at 6-12 months after syphilis therapy. In addition to the above guidelines for 3, 6, 9, 12, and 24 months, any client with a fourfold increase in titer at any time should be referred to private physician of choice/DIS.
4. All HIV positive clients who have not returned for post-test counseling will be referred to a Disease Intervention Specialist (DIS) for post-test counseling within 7 days. The Division of Public Health Services informs the DIS through referral on the day of the results.
5. Referral is the process by which immediate client needs for care and supportive services are assessed and prioritized and clients are provided with assistance.

G. Resources for Health Care or Case Management For HIV Positive Clients:

1. For case management, HIV positive clients may be referred to:
Cone Health Home Care Providers at Alamance Regional HIV Medical Case Management for Alamance, Caswell and Rockingham Counties.

   3025 South Church Street, PO Box 202
   Burlington, NC 27215
   PH: (336) 538-8557

2. Infectious Disease management at Baptist Hospital:
(336) 716-2700

3. UNC-Chapel Hill Hospital/Infectious Disease Management:
   (984) 974-7198 or (866) 241-7586
4. Greensboro Regional Field Services Office
   3409 West Wendover Avenue, Suite G
   Greensboro, NC 27407
   Office (336) 218-5701
   Fax (336) 218-5709
   Toll Free 1 (800)637-6531
5. www.cdc.gov

H. Quality Assurance: The Division of Public Health Services ensures high quality services. The following outline covers areas of concern for monitoring the effectiveness of the HIV CTR services:

1. Accessibility of services: ensuring the availability of the services to our citizens.
2. Ensuring staff compliance with written protocols for provision of service.
3. Ensuring that services provided and materials generated are appropriate to client's culture, language, sex, sexual orientation, age, and developmental level.
4. Staff performance/proficiency with skills, training needs, etc.
5. PHN Supervisor provides supervision to the staff identifying strengths and needs and providing timely feedback.
6. Ensuring compliance with program guidelines and performance standards.
7. Providing appropriateness of services to client needs, and measured with client satisfaction surveys.
8. Appropriate record-keeping procedures, including confidentiality and security.
9. Collaborative arrangements with community resources.
10. Proper collection, handling, and storage of specimens, according to infection control guidelines.
11. Assurance of adequate funding and institutional support for CTR services.
12. Regional DIS completes reporting of all positive HIV tests through the NC EDSS.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: HUMAN PAPILLOMAVIRUS (HPV) PROTOCOLS (GENTIAL WARTS)

DATE DEVELOVED: 4/16/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/22

I. POLICY:

The Advanced Practice Providers (APPs) of the Division of Public Health Services will evaluate, provide diagnosis and treatment plan for clients presenting to the clinical setting with symptoms of the human papillomavirus (HPV). Condylomata acuminata (genital warts) are caused by the human papillomavirus (HPV). The incubation period ranges from 3 weeks to 8 months, with the average being approximately 3 months. HPV is one of the most common STD's. Among men, the incidence is higher in men who are uncircumcised. There is an increased incidence in clients receiving steroids, in those who are infected with HIV disease or malignancy, and in transplant clients. Pregnancy promotes rapid growth of these lesions. Estimates of spread from infected persons to uninfected persons range as high as 70%.

II. PURPOSE:

The APPs of the RCDHHS-Division of Public Health Services will evaluate, diagnose, and treat clients with human papillomavirus (HPV) based on the current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program – Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP). The client will be provided education on the disease, its mode of transmission, treatment options, and prevention of spread to other persons.

III. GUIDELINES:

A. History:

1. For Women:
   a. complaint of new bumps on vulva/perirectal area
   b. vaginal discharge and pruritis can indicate vaginal condyloma
2. For Men:
   a. complaint of bumps or groups of bumps around the penis or anus
   b. urethral itching and dysuria

B. Physical Examination:

1. For Women:
   a. Diagnosis is usually made by clinical appearance
   b. 5% acetic acid may be used to cause acetowhite effect, should HPV be present that may not be observed otherwise.

2. For Men:
   - Diagnosis is usually made by clinical appearance.

C. Investigative Procedures:

Biopsy specimens of vulvar lesions should be taken if they lack the classic appearance, become ulcerated, or fail to respond to therapy. Multiple biopsies should be taken from the large lesions. This service is not done by the APP at the Division of Public Health Services; these clients are referred to a physician.

Cervical abnormalities are usually detected by Pap smears and are evaluated by colposcopy and directed biopsies. The Division of Public Health Services employs medical providers trained to perform these procedures.

D. Management Of External HPV:

1. Trichloroacetic acid or Bichloracetic acid (80%-90%) (administered by APP): Apply in small amount only to warts and allowed to dry. Repeat applications at weekly intervals if necessary. Clients are provided with post treatment care instructions by the APP.

2. Patient applied Aldara (Imiquimod 3.75% or 5% cream): Apply at bedtime 3x/week for 16 weeks max or as directed by medical provider. Each application should be washed off after 6-10 hours. In most patients warts disappear in 8 to 12 weeks. Many people see reddening at the wart area during treatment, which is usually not painful.

3. Patient applied Podofilox 0.5% solution or gel: apply to visible warts BID for 3 days, followed by 4 days of no therapy, repeated for 4 cycles max or as directed by APP.

4. Patient applied Sinecatechins 15% ointment: apply to visible warts TID daily until lesions resolve, or up to 16 weeks or as directed by APP.

E. Management of intra-vaginal HPV: Referral to OBGYN provider.

F. Management of males with symptoms but not consistent with HPV lesions: refer to urologist for evaluation for urethral lesions.

G. Oral Warts: Refer to ENT.

H. Treatment of genital warts should be guided by the preference of the patient, available resources, and experience of the healthcare provider. The treatment modality should change if there is not improvement and/or resolution after six treatments. In general, warts on moist surfaces and/or in intertriginous areas respond better to topical treatment than do warts in drier areas.

I. After visible genital warts have cleared, a follow-up evaluation is not mandatory but may be helpful. Clients should be counseled to watch for recurrences which occur most frequently during the first three (3) months.

J. Clients diagnosed with genital warts (HPV) are advised to establish care with a primary care provider to establish an on-going treatment plan. Clients are provided with community resources for care including follow-up at the Division of Public Health Services Adult Primary Care Clinic.

K. Clients may be seen in the STD Program clinic by the APPs experienced in this care after the initial diagnosis with this service provided as Adult Primary Care per Adult Primary Care guidelines and applicable fee schedule.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines 2021 @ www.cdc.gov

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: GONORRHEA PROTOCOLS

DATE DEVELOPED: 5/94
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 1/23; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/21; 6/22; 1/23

I. POLICY:

The professional staff of the Division of Public Health Services will assess and/or evaluate clients for Gonorrhea. Gonorrhea is caused by a gram-negative, intracellular diplococcus Neisseria Gonorrhoeae, which has avidity for columnar and transitional epithelium. Urogenital purulent inflammation is the most common form of this infection. Transmission is usually by sexual contact, with a usual incubation period of 2-8 days. Gonorrhea is the second most common sexually transmitted disease in the United States following Chlamydia as the most common. Often the two diseases occur concurrently; thus, the infections are often treated simultaneously.

II. PURPOSE:

The clinical staff of the Division of Public Health Services will screen and treat clients presenting with symptoms and/or as a contact to Gonorrhea based on the current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program – Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP).

III. GUIDELINES:

A. Physician Consultation and/or Referral:
If any of the following are present prior to treatment, consult with and/or refer to Advanced Practice Provider (APP) as directed in the assessment protocol:

1. Inflammation of the pharynx
2. Inflammation of the rectum
3. Acute abdominal tenderness or rebound tenderness on exam
4. Adnexal tenderness on exam/Cervical motion tenderness on exam
5. Sustained cervical bleeding on exam or ANY reported vaginal spotting/bleeding by a pregnant client
6. Scrotal pain or swelling
7. Oral temperature $\geq 101^{0}$ F
8. Client has an IUD
9. Inflammation of a joint
10. Skin lesions
11. Dyspnea and rapid heart rate (symptoms of endocarditis)
12. Treatment failure indicated by persistence of symptoms

(persistence or recurrence of symptoms greater than 3 to 5 days after initial treatment is completed and without re-exposure; or presents with a repeat positive culture or positive NAAT at least 2 weeks after initial treatment is completed without re-exposure. Contact the EPI on call with the Communicable Disease Branch to discuss possible testing for drug resistance.)

13. Symptoms/signs of Gonococcal Opthalmia
14. Disseminated GC (DGI)
15. Symptoms/signs of meningitis
16. If the client is not an adolescent or adult weighing at least 45 kg (99 lbs), consult the medical provider or medical director for appropriate treatment.

B. History:

1. Male Clients:

   a. penile discharge
   b. dysuria
   c. epididymitis symptoms
   d. pharyngitis
   e. proctitis
   f. disseminated infection involving dermatitis, tenosynovitis, and arthritis; rarely, it may cause meningitis and endocarditis
   g. symptoms may be subtle, or non-existent, but usually males present with the more common symptoms (see a and b above)

2. Female Clients:

   a. vaginal discharge
   b. urinary frequency and dysuria
   c. menstrual irregularity
   d. bilateral lower abdominal pain
   e. oral or anal mucosal infection may lead to pain and discharge
   f. septic arthritis
   g. skin lesions
   h. PID symptoms
   i. May be Asymptomatic
   j. (see "f" under Male Clients)

C. Physical Examination/Testing: (see "Clinical Protocols for STD Client Exam STD-2".)

D. Management: Includes treatment for clients presenting with signs and symptoms of uncomplicated (none of the conditions listed in "A")

Gonorrhea and/or who are a sexual contact to a known case of Gonorrhea or who have had a positive laboratory test result for Gonorrhea.

Uncomplicated Gonococcal Infections of the Cervix/Vagina, Urine, Urethra, Pharynx or Rectum*

Recommended Regimens

1. For any lab confirmed Gonorrhea infection at any site, administer Ceftriaxone* 500 mg IM as a single dose for persons weighing > 45 kg (99 lbs) and < 150 kg (330 lbs). For persons weighing ≥ 150 kg (330 lbs) treatment with 1 gram of IM Ceftriaxone should be administered.
2. For any verified contact of Gonorrhea case, administer Ceftriaxone* 500 mg IM as a single dose for persons weighing > 45 kg (99 lbs) and < 150 kg (330 lbs). For persons weighing ≥ 150 kg (330 lbs), 1 gram of IM Ceftriaxone should be administered.
3. For empiric treatment (including empiric treatment of any sex partners) or presumptive positive lab in non-pregnant clients when Chlamydia has not been ruled out, administer Ceftriaxone* as listed above in recommended regimen 1 AND Doxycycline 100 mg orally BID for 7 days.
4. For any verified nonpregnant contact of a Gonorrhea case where Chlamydia has not been ruled out, administer Ceftriaxone* as listed above in recommended regimen 2, AND Doxycycline 100 mg orally BID for 7 days.
5. For treatment of presumed pregnant or pregnant clients when Chlamydia has not been ruled out, administer Ceftriaxone* as listed above in recommended regimen 1, AND Azithromycin 1 gram orally in a single dose.

*Ceftriaxone may be used in patients reporting allergy to penicillin IF the allergic response does NOT include anaphylaxis, Stevens-Johnson or toxic epidermal necrolysis.

If the client has a history of anaphylaxis when given a Penicillin and/or Cephalosporin medication, contact a medical provider for a consult and/or individual treatment order.

ALTERNATIVE REGIMENS FOR UNCOMPLICATED GONOCOCCAL INFECTIONS OF THE CERVIX, URETHRA, OR RECTUM IF CEFTRIAXONE IS NOT AVAILABLE: (CHECK QUALIFIERS FOR EACH REGIMEN CLOSELY!)**

- For nonpregnant clients, Gentamicin 240 mg IM as a single dose plus Azithromycin 2 grams orally as a single dose.

- For nonpregnant clients when Chlamydia infection **HAS NOT** been ruled out, Cefixime 800 mg orally as a single dose AND Doxycycline 100 mg PO BID x 7 days.
- For pregnant clients when Chlamydia infection **HAS NOT** been ruled out, Cefixime 800 mg orally as s single dose AND Azithromycin 1 gram orally in a single dose.
- For pregnant clients when Chlamydia infection **HAS** been excluded, Cefixime 800 mg orally as a single dose.

**No reliable alternative treatments are available for pharyngeal Gonorrhea. For persons with a history of a beta-lactam allergy, a thorough assessment of the reaction is recommended. For more information, see the current STD Treatment Guidelines. For persons with an anaphylactic or other severe reaction (e.g., Stevens Johnson Syndrome) to Ceftriaxone, consult an infectious disease specialist for an alternative treatment.

*These regimens are recommended for all adult and adolescent clients and including children >45 kg (99 lbs).

E. Counseling/Instructions to Client:

1. Abstain from sexual intercourse for seven days after single day treatments or until after the completion of 7-day medication regimen.
2. Advise client to abstain from sex until partner(s) have completed their treatment and abstain from sex for 7 additional days.
3. Correct condom use, as well as client-specific counseling and literature about personal risk behavior.
4. Disinfect diaphragm per manufacturer's instructions, if this is the client's method of birth control.
5. Use back-up contraceptive while on medication and for seven days after completion of medication for female clients who are taking oral contraceptives.
6. Deliver partner referral card(s) for all recent (within 60 days) sexual partner(s) or if last exposure was > 60 days before onset of symptoms, instruct client to notify the most recent sexual partner(s) they are to have an STD exam, testing, and treatment.
7. Notify all sexual partners to take the partner referral card to their medical provider or local public health department.
8. Learn about the relationship between STDs and HIV acquisition.
9. Request repeat HIV testing in the future if ongoing risk factors (i.e., persons with multiple partners should be tested every three (3) months, etc.).
10. Use other disease prevention barrier methods such as dental dams, if applicable.
11. To clean and cover sex toys, per manufacturer's instructions, if applicable, to decrease transmission of infections.

12. Women who are pregnant should not be treated with quinolones or tetracyclines (Doxycycline, Levofloxacin, Ciprofloxacin).

13. Counsel the client about the specific medication(s) administered, dispensed or prescribed:

    Ceftriaxone, and/or
    Doxycycline, and/or
    Gentamicin, and/or
    Cefixime, and/or
    Azithromycin

    - If a single dose medication is vomited within 2 hours after taking oral medication or the medication is seen in the vomitus, advise client to contact the clinic as soon as possible to report this for further instructions, as indicated.
    - Advise client that she/he may experience side effects such as nausea, vomiting, cramps, diarrhea or headache;
    - Advise female clients not to become pregnant while on Doxycycline.
    - Reinforce counseling by providing the client with the appropriate medication teaching information.
    - Seek urgent or emergency care if any of the following develops within 30 minutes after treatment: shortness of breath, tongue, throat or facial itching or swelling, chest pain or heaviness, abdominal pain, scrotal pain, or oral temperature $\geq$ 101°F.

F. Follow-up:

1. Assure disease reporting occurs via the NC Electronic Disease Surveillance System (NC EDSS) with entry of lab test results and treatment information within 30 days.
2. Document the rationale in NC EDSS if the treatment given is not first-line or one of the Alterative Regimens recommended in the most current CDC STD treatment guidelines.
3. Clients whose symptoms persist, worsen, or reappear after treatment should return to the Division of Public Health Services' STD clinic for re-evaluation.
4. Partner follow-up per agency protocol.
5. Clients treated for a positive Gonorrhea test should be re-screened upon any encounter greater than 3 months to 12 months after treatment due to high risk for reinfection.
6. Schedule return to clinic 14 days after treatment completion for test of cure (TOC) by culture if Gonococcal infection was of pharynx regardless of treatment regimen used.

7. Retreat all contacts if index case is determined to be a treatment failure by the medical provider. Consult the medical provider for individual orders for treatment.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Update to CDC's Treatment Guidelines for Gonococal Infection, 2020.
Citation for this article: St. Cyr S, Barbee L, Workowski KA, et al. Update to CDC's Treatment Guidelines for Gonococcal Infection, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1911–1916.

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: VULVOVAGINITIS INFECTIONS

DATE DEVELOPED: 9/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/22

I. POLICY:

The professional staff of the Division of Public Health Services will screen and evaluate clients presenting to the Family Planning/STD Program with symptoms of a vulvovaginitis. Vulvovaginitis is the most common of all outpatient GYN problems. By using current knowledge and simple clinic laboratory methods, a precise etiologic diagnosis can be made for more than 95% of clients. The approach to diagnosing the client with vulvovaginitis consists of a careful history, pelvic examination, and microscopic examination of the vaginal fluid. All three parts of the evaluation contribute to and are essential for a precise diagnosis. The common causes of vulvovaginitis are candidiasis, bacterial vaginosis, trichomonas, cervicitis, chemical or irritative causes, and atrophic vulvovaginitis.

II. PURPOSE:

Clients with a diagnosis of vulvovaginitis will be treated based upon current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program-Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP). Detection, counseling/ education and care for vulvovaginitis or sexually transmitted infections that pose a significant threat to the public improve the health of people in Rockingham County and North Carolina. These efforts aid the reduction of morbidity and mortality resulting from communicable diseases.

III. GUIDELINES:

A. HISTORY: The classic presentation of vaginitis is found in fewer than 33% of cases. The discharge color, presence of pruritis, and the color of the cervix may lead to inappropriate diagnosis and therapy. Treatment based on symptoms alone has been clearly shown to be inaccurate and should be avoided. The following questions should be asked of all women presenting with any vulvovaginitis complaint:

1. Focus on changes from her personal norm.
2. Discharge: Most women have some degree of leukorrhea. “How is the current discharge different?”

3. Odor: Is it constant, does odor occur after coitus, what does the odor smell like?
4. Pruritis: Is there a pattern to the itching; does the itching seem to be internal, external, or both?
5. Burning: Is there burning with urination; does the burning occur while urinating; does the burning occur as the urine touches the skin?
6. How long have symptoms been occurring? What makes them worse/better?
7. Skin irritations or lesions
8. Sexual activity/history
9. Current medications and contraception method
10. Menses history
11. Feminine hygiene products
12. What medications have been tried for this occurrence, if applicable?
13. Systemic diseases: some systemic diseases can cause vulvovaginitis. A few of these include:
    a) Diabetes mellitus
    b) AIDS
    c) Rheumatoid arthritis
    d) Lupus
    e) Hodgkin's disease
    f) Leukemia
    g) Skin diseases, such as psoriasis and eczema

B. Physical Exam/Lab Tests: see "Clinical Protocols for STD Client Exam STD-2".

C. Treatment for Vulvovaginitis: Symptomatic Bacterial Vaginosis (BV) must be documented and treated based on at least 3 of the 4 criteria listed:

- Physical examination reveals a white to gray, thin homogenous vaginal discharge that smoothly coats the vaginal wall;
- PH of vaginal secretion is > 4.5;
- Positive whiff test-fishy odor from vaginal discharge with or without 10% KOH (potassium hydroxide);
- Presence of clue cells on microscopic examination of wet prep.

Note: NC STD Public Health Program – CDC DSTDP recommendation for Bacterial vaginosis is only to treat symptomatic individuals.

1. Bacterial Vaginosis in adults and adolescents:

    a. Non pregnant client (recommended treatment):
        1) Metronidazole 500 mg PO BID x 7 days, or
        2) Metro Gel 0.75% one full applicator (5g) intravaginally once a day x 5 days, or

3) Clindamycin cream 2%, one full applicator (5g) intravaginally at bedtime x 7 days, or

b. Non pregnant client (alternative treatment):

1) Clindamycin 300 mg PO BID x 7 days, or
2) Clindamycin ovules 100 mg intravaginally at bedtime x 3 days.
3) Secnidazole 2 gm orally in a single dose
4) Tinidazole 2 gm PO 1 x day for 2 days, or
5) Tinidazole 1 gm PO daily x 5 days

c. Pregnant client: It is left to the discretion of the physician extender regarding whether she/he treats a pregnant client. The Division of Public Health Services does not provide prenatal services. However, should the physician extender choose to treat the pregnant client, the recommended treatment is Metronidazole 250 mg PO TID x 7 days.

*Alternative treatments for pregnant clients include regimens listed above for non- pregnant clients. Tinidazole should be avoided in pregnancy.

*Treatment is recommended for all symptomatic pregnant women.

- An uninsured client's initial diagnosis of symptomatic BV (diagnosed during a clinical or screening visit at RCDHHS-Division of Public Health) will be treated using state-supplied oral Metronidazole.

- Uninsured clients presenting with recurrent episodes of BV will be given an in-house medication order and directed to the in-house pharmacy to purchase oral Metronidazole. Metronidazole for recurrent BV, as well as some alternative treatments, is not purchased with 340B funds. (See STD pharmaceuticals list for drugs approved for purchase with 340B funds.) These treatments are provided at a low cost for the convenience of our clients via local county funding.

- Clients who have Medicaid or other private insurance will be provided an electronic prescription order sent to the pharmacy of the client's choice for Metronidazole, or alternative treatment, per the medical provider.

2. Candidiasis in adults and adolescents:

Candidiasis must be documented and treated based on client report of symptoms and identification of typical yeast (budding cells or pseudohyphae) on microscopic examination of a smear of vaginal discharge by saline or KOH wet mount.

Non pregnant clients:

a. Diflucan 150 mg PO x 1 dose only per Physician Extender order; or Terconazole 0.4% vaginal cream, 1 applicator full daily at bedtime x 7 days.

b. Client may also purchase OTC antifungal vaginal medication (see Candidiasis Standing order for treatment recommendation ST-STD-2); or

c. Terconazol 0.4% Vaginal Cream may be prescribed as recommended by the Physician Extender for our uninsured clients with this treatment available at low cost to clients via local county funding or a prescription may be provided to clients with Medicaid/private insurance.

- Uninsured clients may obtain Fluconazole 150 mg PO x 1 dose, if prescribed by the Physician Extender, from the Health Department Pharmacy after payment of the current pharmacy fee.
- Clients who have Medicaid or other private insurance will be provided an electronic prescription order sent to the pharmacy of the client's choice for Fluconazole, or alternative treatment, per the Physician Extender.

3. Trichomonas vaginitis in adults and adolescents:

Trichomoniasis must be documented and treated based on client report of symptoms and identification of motile, flagellated T. Vaginalis on microscopic examination of a smear of vaginal discharge by saline or KOH wet mount or identification of T. Vaginalis by culture or NAAT (recommend only treat T. Vaginalis found in urine, urethral or vaginal specimens); verified client contact to a sexual partner positive for Trichomoniasis or referral by medical provider for treatment of Trichomoniasis.

a. For female cases or verified female contacts to a confirmed case:

- Metronidazole 500 mg (1) PO BID for seven (7) days if client is not allergic**

**This regimen will treat concurrent Bacterial Vaginosis as well

Alternative Treatment:

Tinidazole 2 gm PO in a single dose if not pregnant

* Tinidazole should be avoided in pregnant women

b. For male cases or verified male contacts to a confirmed case:

- Metronidazole 2 gm PO in a single dose

Alternative Treatment:

Tinidazole 2 gm PO in a single dose

c. Partners of clients with positive Trichomoniasis infections: Partners are to be notified by the client in order to prevent spread of the disease. The client will inform sexual partner that they will need to be examined, tested, and treated at the time of their visit.

d. Verbal instructions should be supported with written material:

- Client and partner(s) should abstain from sexual intercourse for 7 days after single-dose therapy and until 7 days after completion of 7-day regimen.
- Delay start of treatment with Metronidazole until at least 24 hours after last alcoholic beverage, or 72 hours for Tinidazole. Avoid alcohol during treatment. Refrain from alcohol use for 24 hours after the last dose of Metronidazole or 72 hours after last dose of Tinidazole as it leads to nausea and abdominal pain.
- Counsel about risk of HIV infection and encourage HIV testing.
- Use abstinence or condoms until all partners are treated and fully recovered.

e. Advise breastfeeding client that due to lower concentrations of Metronidazole in breast milk, when receiving 500 mg PO BID the breastfeeding client does not have to discard breast milk while taking Metronidazole.

f. Advise clients with positive T. Vaginalis test results of need for rescreening for reinfection in 3 months, sooner if s/s recurrence

g. Contact RCDPH for instructions if symptoms persist, worsen, or reappear within 2 weeks after treatment;

h. See urgent or emergency care if any of the following develops within 30 minutes after treatment: shortness of breath, tongue, throat, or facial itching or swelling, chest pain or heaviness, abdominal pain, scrotal pain or temperature $\geq$ 101°F after taking medication.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SCABIES PROTOCOL

DATE DEVELOPED: 4/16/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/22

I. POLICY:

The Family Planning/STD Program Physician Extender of the Division of Public Health will assess and/or evaluate clients with symptoms of Scabies presenting for STD screening/services. Scabies infestation is caused by the mite Sarcoptes scabiei. Like the crab louse, its entire life cycle can be completed on humans. The adult female burrows into the skin and remains there for life, approximately 30 days. She rapidly begins laying two to three eggs per day, which become adult mites in 10 days. However, fewer than 10% of the eggs will become adults. The average client with scabies has only 10-15 live adult female mites on the body at any one time. The mites can survive for only 2-3 days at room temperature apart from humans. Transmission is by direct, prolonged, skin-to-skin contact with a person who has scabies. Scabies are rarely transmitted by fomites (sheets, towels, or clothing) or by casual contact.

II. PURPOSE:

The Physician Extender of the Division of Public Health Services will evaluate, diagnose and treat clients for scabies based on the current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program – Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP). Detection, counseling/ education and care for sexually transmitted infections that pose a significant threat to the public improve the health of people in Rockingham County and North Carolina. These efforts aid the reduction of morbidity and mortality resulting from communicable diseases.

III. GUIDELINES:

A. History: The primary symptoms are pruritis and a rash that is caused by sensitization to the mite. In primary infestation, it takes 4-6 weeks for these to occur, although in reinfestation, symptoms may appear within 24 hours. The pruritis is typically nocturnal. Because the immune system must be intact for a response, those clients with a depressed immune system may not itch.

B. Physical examination: The rash is usually symmetric and located primarily on the wrists, elbow, armpit, webbing between the fingers, belt line, nipple,

waist, penis, and the lower portion of the buttocks. The pathognomonic lesion is the burrow, which is a short, wavy, dirty-appearing line. Excoriation of these lesions can lead to secondary infection with furunculosis, pyoderma, cellulitis, septicemia, and other signs of systemic bacterial infection.

C. Investigative procedures: A presumptive diagnosis is made by observing the typical burrows in a symptomatic client. A definitive diagnosis can be made by demonstrating the mite, the fecal pellets, or the burrow by special tests.

1. A drop of mineral oil can be placed on the skin lesions, which are then scraped with a scalpel blade and transferred to a glass slide for observations through the microscope.
2. The lesions can be moistened with alcohol, then scraped and transferred to a microscopic slide. Adding 20% potassium hydroxide to the slide and heating gently will aid in clearing epidermal debris.

D. Management:

1. Elimite (Permethrin 5%) cream for presence of scabies < 2 months; not recommended for scabies > 2 months. Massage into skin from head to soles of feet. Remove 8-14 hours later by washing. Usually one treatment suffices. Infants and young children (aged < 5 years) should be treated with Permethrin. Infants: also treat scalp, temples, and forehead; or
2. Ivermectin 200 µg/kg body weight orally, repeated in 14 days (Oral Ivermectin has limited ovicidal activity, a second dose is required for cure); or
3. Ivermectin 1% lotion applies to all areas of the body (from neck down) wash after 8-14 hours; repeat treatment in 1 week if symptoms persist; or
4. Lindane 1% (Kwell) 1 oz. of lotion or 30 g of cream applied thinly to all areas of the body from the neck down to the toes and washed off thoroughly after 8 hours. (Infants and children aged <10 years should not be treated with Lindane.)

Note: Lindane 1% - Contraindicated for pregnant or lactating women. This should not be used after a bath or by persons with extensive dermatitis.

E. Follow-up: Sexual or close contact should be avoided until after treatment. Pruritis may persist for several weeks after adequate treatment. Since eggs may survive, a second treatment may be necessary if client shows no clinical improvement after one week. Additional weekly treatments are warranted only if live mites are present.

F. Counseling/Education: Clients should understand:

1. how to apply prescribed medication
2. return to clinic after 1 week if symptoms persist
3. refer sex partner(s) for treatment
4. avoid sex until client and partner(s) are treated

G. Evaluation of sex partners: All sex partners and household contacts of clients who have scabies infection should be promptly treated. Sex partners may benefit from an evaluation for other STDs.

H. Special considerations: Decontamination of clothing, bed linens, and towels that may have been contaminated by the client within the past 2-3 weeks should be washed and dried by machine, on hot cycle, or dry cleaned. Articles that cannot be washed or dry-cleaned can be decontaminated by sealing in a plastic bag or placed in a sealed container for at least 72 hours (removed from any body contact).

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: NONGONOCOCCAL URETHRITIS (NGU) PROTOCOLS

DATE DEVELOPED: 6/12/95
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/18; 6/22

I. POLICY:

The professional staff, as well as the Advanced Practice Providers (APPs) of the Division of Public Health Services Family Planning/STD program will assess and treat clients presenting to the clinical setting with symptoms of nongonococcal urethritis (NGU) and verified contacts of NGU. Urethritis is caused by an infection characterized by: urethral discharge or recent history of urethral discharge, dysuria, urethral inflammation, intra-meatal itching, or asymptomatic with history of new or multiple sex partners.

II. PURPOSE:

The professional staff, as well as the APPs of the Division of Public Health Services will screen, diagnose and treat clients with symptoms of NGU based on current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program – Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP). Clients will be counseled and provided with education on prevention and spread of sexually transmitted infections.

III. GUIDELINES:

The following protocol is initiated when a client presents with symptoms, as a referral (referred by Physician, Partner Card, DIS, or partner), or is a partner of a lab-confirmed case of Chlamydia, or is a partner of a diagnosed case of NGU. If a client presents to the STD clinic stating that he is a contact to Chlamydia or to a person who has been diagnosed with NGU, the health department staff should verity the diagnosis of the named partner (index case) for the client to be treated as a contact. For women who are contacts of a case of NGU, follow Chlamydia treatment protocols.

A. Medical Provider Consultation and/or Referral for Males:

If any of the following are present, consult with or refer to APP as directed in the assessment protocol:

1. Swollen, painful scrotum
2. Prostatitis
3. Treatment failure indicated by persistent symptoms

B. Physical Examination/Testing: (see "Clinical Protocols for STD Client Exam STD-2".)

C. Recommended Drug Regimen:

Male clients and nonpregnant female clients: dispense or prescribe Doxycycline 100 mg PO BID x 7 days.

Alternative Regimens:

1. If client is allergic to Doxycycline, administer Azithromycin 1 gm PO in a single dose.
2. If client is pregnant or assumed to be pregnant, administer Azithromycin 1 gm PO in a single dose (Doxycycline is contraindicated in pregnancy); or
3. Azithromycin 500 mg orally in a single dose, THEN 250 mg once daily for 4 days.

D. Instructions to Client:

The RCDHHS-Division of Public Health will provide the option of Chlamydia/Gonorrhea urine NAAT testing to asymptomatic male clients (when there are no clinical findings on exam or complaints of urethral symptoms, but urethral exposure within the last 60 days) as well as to symptomatic male clients (including men who present with a complaint of urethral discharge, dysuria or intrameatal itching during the interview and have clinical findings on exam) who do not meet the NCSLPH criteria for free NAAT testing. Clients not qualifying for free NAAT testing, who choose this testing will be responsible for the contracted cost of the test at the time of the clinical visit. Male clients will also be provided the option of Trichomoniasis urine NAAT testing as this testing is not offered by NCSLPH. Clients choosing this testing will be responsible for the contracted cost of the test at the time of the clinical visit. Asymptomatic male clients not choosing NAAT urine testing will receive standard bacterial gram stain/Gonorrhea culture testing. Symptomatic male clients will receive standard bacterial gram stain/Gonorrhea culture testing even if opting to self-pay for urine NAAT testing.

1. Persistent or recurrent NGU:

    a. Consider Mycoplasma Genitalium testing if available (per APP order).
    b. Test for Trichomoniasis Vaginalis in heterosexual males when available (offer testing for males; see testing options above).

2. Abstain from sexual intercourse for seven days after single day treatments or until 7 days after the completion of 7-day medication regimen.
3. Advise client to abstain from sex until partner(s) have completed their treatment.
4. Correct condom use as well as client-specific counseling and literature about personal risk reduction behavior.
5. Disinfect diaphragm per manufacturer's instructions, if this is the client's method of birth control.
6. Use back-up contraceptive while on medication and for seven days after completion of medication for female clients who are taking oral contraceptives.
7. Deliver partner referral card(s) for all recent (within 60 days) sexual partner(s) or if last exposure was > 60 days before onset of symptoms, instruct client to notify the most recent sexual partner(s) they are to have an STD exam, testing, and treatment.
8. Notify all sexual partners to take the partner referral card to their medical provider or local public health department.
9. Learn about the relationship between STDs and HIV acquisition.
10. Request repeat HIV testing in the future if ongoing risk factors (i.e., persons with multiple partners should be tested every three (3) months, etc.).
11. Use other disease prevention barrier methods such as dental dams, if applicable.
12. To clean per manufacturer's instructions and cover sex toys, if applicable, to decrease transmission of infections.
13. Women who are pregnant should not be treated with quinolones or tetracyclines (Doxycycline, Levofloxacin, Ciprofloxacin).

E. Follow-up:

1. Report to the state through the North Carolina Electronic Disease Surveillance System (NC EDSS); this is done by the Communicable Disease Coordinator or other designated/trained staff.
2. Clients reporting symptoms that continue to persist, worsen, or reappear after treatment should return to the STD clinic for re-evaluation:

   Persistent or recurrent NGU treatment recommendations:

   If M. Genitalium resistance testing is unavailable, but M. Genitalium is detected by an FDA-cleared NAAT test:

   <u>Recommended regimen:</u>

   Doxycycline 100 mg PO BID x 7 days, FOLLOWED BY Moxifloxacin 400 mg daily x 7 days.

Alternative regimen for settings without resistance testing and when Moxifloxacin cannot be used:

Doxycycline 100 mg PO BID x 7 days PLUS Azithromycin 1 gm on the first day PLUS Azithromycin 500 mg daily x 3 days and a Test of cure 21 days after completion of therapy.

*Note-If resistance testing is available, use resistance-guided therapy

Heterosexual men who live in areas where Trichomoniasis Vaginalis is highly prevalent:

Metronidazole 2 gm orally in a single dose; or
Tinidazole 2 gm orally in a single dose

3. Partners should follow-up per agency protocol as stated above.
4. Males diagnosed with NGU per standard bacterial gram stain and those with a specific diagnosis of Chlamydia, Gonorrhea, or Trichomoniasis should return 3 months after treatment for repeat testing because of high rates of reinfection.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PEDICULOSIS PUBIS PROTOCOLS

DATE DEVELOPED:
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/22

I. POLICY:

The professional staff, as well as the Advanced Practice Providers (APPs) of the Division of Public Health Services will assess clients presenting to the Family Planning/STD Program with symptoms of pediculosis pubis. The causative organism for pubic lice is Phthirus pubis (crab louse), which is different from body or head lice. Its life cycle is approximately 25 days and can be completed entirely on the human host. Soon after reaching maturity, impregnated females begin laying eggs (nits) that hatch in 7-8 days. Each egg is cemented to a single hair shaft.

Transmission is generally by direct body contact, usually sexual. Pubic lice are the most contagious sexually transmitted disease known, and the risk of acquiring the infestation is approximately 95% after a single exposure.

II. PURPOSE:

The APPs of the Division of Public Health Services will screen, diagnose and treat clients with symptoms of pediculosis pubis based on the current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program – Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP). Detection, counseling/ education and care for sexually transmitted infections that pose a significant threat to the public improve the health of people in Rockingham County and North Carolina. These efforts aid the reduction of morbidity and mortality resulting from communicable diseases. Clients will be counseled and provided with education on prevention and spread of pediculosis pubis.

III. GUIDELINES:

A. History: The chief complaint of infested persons is pruritis and, because of autosensitization, it is not always localized to the affected sites. Clients may report seeing organisms move in their pubic hair.

B. Physical examination: The louse is usually found in the pubic area. Nits may be seen at the base of the pubic hair shafts. Scratching may lead to secondary excoriations, which may predispose to lymphadenitis or pyoderma. The infested client may also present with a symptomatic bluish, non-blanching, nodular rash on the lower trunk and upper thighs, known as

maculae ceruleae. This rash is believed to be either secondary to altered blood pigments in the client or an excretory substance from the louse's salivary glands.

C. Investigative procedures: A bright light source, in addition to a magnifying glass, is helpful in assessing for the presence of nits or adult lice. The louse may be put on a glass slide and observed under the microscope. The louse looks like a miniature crab.

D. Management:

1. **Recommended treatments:** Permethrin 1% crème rinse, apply to affected area, wash off after 10 minutes, or
2. Pyrethrins with piperonly butoxide apply to affected area, wash off after 10 minutes.
3. **Alternative treatments:** Malathion 0.5% lotion, applied to affected areas and wash off after 8-12 hours, or Ivermectin 250 ug/kg body weight orally, repeated in 7-14 days.
4. Clients should be re-evaluated after one week if symptoms persist. Re-treatment may be necessary if lice or nits are found at the hair-skin junction.
5. All sexual contacts of the infested person should be examined. All those who are infested should be treated.
6. Machine wash and dry clothing worn and bedding used by the infested person in the hot water (at least 130°F) laundry cycle and the high heat drying cycle. Clothing and items that are not washable can be dry-cleaned OR sealed in a plastic bag and stored for 2 weeks. RID spray may be used on items that cannot be washed, use per manufacturer's directions.
7. Do not share clothing, bedding, and towels used by an infested person.
8. Do not use fumigant sprays or fogs; they are not necessary to control pubic ("crab") lice and can be toxic if inhaled or absorbed through the skin.
9. Explain that condoms will not prevent transmission from areas that cannot be covered by a condom.
10. Sexual contact between the infested person(s) and their sexual partner(s) should be avoided until all have been examined, treated as necessary, and reevaluated to rule out persistent infestation.
11. Importance of following instruction for application of topical treatment and washing off.
12. Persons with pubic lice should be examined and treated for any other sexually transmitted diseases (STDs) that may be present.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PROTOCOL FOR CONTACT TO SYPHILIS

DATED DEVELOPED: 5/23/93
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/22

I. POLICY:

The professional staff, as well as Advanced Practice Providers (APPs) of the Division of Public Health Services Family Planning/STD Program will access and/or evaluate all clients presenting as a contact to Syphilis and requesting STD screening/services. Referrals may be made by DIS, physician or clients presenting to the clinic requesting to be screened as a partner referral.

II. PURPOSE:

The professional staff, as well as APPs of the Division of Public Health Services will screen, evaluate and treat clients as a contact to Syphilis based on the current guidelines of the North Carolina Sexually Transmitted Diseases Public Health Program-Centers for Disease Control and Prevention Division of Sexually Transmitted Diseases Prevention and DIS intervention. Detection, counseling/education and care for sexually transmitted infections that pose a significant threat to the public improve the health of people in Rockingham County and North Carolina. These efforts aid the reduction of morbidity and mortality resulting from communicable diseases. Clients will be counseled on the prevention and spread of Syphilis. (See STD-14 Syphilis Protocols)

III. GUIDELINES:

Persons sexually exposed to a client with early Syphilis should be evaluated clinically and serologically. If the exposure occurred within the previous 90 days, the person may be infected yet seronegative and therefore, should be presumptively treated. (It may be advisable to presumptively treat persons exposed more than 90 days previously if serologic test results are not immediately available and follow-up is uncertain.) Guidance is generally provided by Regional Disease Intervention Specialists (DIS).

A. Screen for all STD's:

1. Gonorrhea culture and/or gram stain slide for males
2. RPR lab test for Syphilis (RPR titer if RPR reactive)
3. HIV screening
4. Gen probe for Gonorrhea and Chlamydia for females
5. Wet mount for females

6. Pharyngeal or rectal Gonorrhea culture as indicated by client history and sexual risk assessment for males/females
7. Urine NAAT for Gonorrhea/Chlamydia for symptomatic/ asymptomatic males if client chooses this optional testing. (See STD Policy 2, Clinical Protocols for STD Client Examination)
8. Urine NAAT for Trichomoniasis for symptomatic/asymptomatic males if client chooses this optional testing. (See STD Policy 2, Clinical Protocols for STD Client Examination).

B. Treatment:

1. Recommended regimen: Benzathine Penicillin G (Bicillin LA) 2.4 million units IM (either as a single 2.4 mu injection or split into two (2) 1.2 mu* injections given in each buttock).

   * Preferred method of delivery for patient comfort.

   *Note: Pregnant clients allergic to Penicillin should be treated with Penicillin after desensitization.

2. Alternative recommended regimen if allergic to Penicillin and not pregnant:

   Doxycycline 100 mg PO BID x 14 days, or

   Tetracycline 500 mg PO QID x 14 days

   - Penicillin-allergic clients who cannot tolerate Doxycycline should have their allergy confirmed.

   Doxycycline and Tetracycline are equivalent therapies. There is less clinical experience with Doxycycline, but compliance is better. In clients who cannot tolerate Doxycycline or Tetracycline:

   - If follow-up or compliance cannot be ensured, the client should have skin testing for Penicillin allergy and be desensitized, if necessary.

3. Pregnant Client: Contact STD regional office and refer client to DIS for assistance in skin testing and desensitization procedure.

C. Injections of long acting Benzathine Penicillin G (Bicillin LA) are administered at the Division of Public Health Services and some private primary care physician offices.

D. Treatment administered at the Division of Public Health Services is provided based on recommendations of Regional DIS and/or per order of the APP.

E. Instructions to Client:

1. Abstain from sexual intercourse for seven days after single day treatments or until 7 days after the completion of alternative 14-day medication regimen.
2. Correct condom use as well as client-specific counseling and literature about personal risk reduction behavior.
3. Caution female clients taking oral contraceptives to use back-up method for birth control while on antibiotic(s) therapy and for 7 days after completion. (Client should not be sexually active until all sexual partners are evaluated and treated, 7 days after single dose treatment or until 7 days after all oral medication is completed.)
4. Caution female clients to not get pregnant while taking Doxycycline.
5. Counsel clients regarding the importance of early re-evaluation if symptoms persist or recur.
6. Learn about the relationship between STDs and HIV acquisition.
7. If abdominal pain or fever develops, call the clinic at the Division of Public Health Services. This is very important if the client has an IUD.
8. If the client is using a diaphragm, it needs to be disinfected per manufacturer's instructions.
9. Women who are pregnant or assumed pregnant should not be treated with tetracyclines (Doxycycline).
10. Syphilis has been associated with an increased risk of acquiring HIV. Clients diagnosed with Syphilis should be tested for HIV.
11. Doxycycline may cause side effects such as nausea, abdominal pain, vomiting, diarrhea, rash, urticaria, photosensitivity, and increased pigmentation.
12. Request repeat HIV testing in the future if ongoing risk factors (i.e., persons with multiple partners should be tested every three (3) months, etc.).
13. Use other disease prevention barrier methods such as dental dams, if applicable.
14. To clean per manufacturer's instructions and cover sex toys, if applicable, to decrease transmission of infections.

Counsel the client regarding the possibility of developing the Jarisch-Herxheimer reaction within 24 hours of treatment for Syphilis.

- Symptoms may include fever, malaise, headache, musculoskeletal pain, nausea, and tachycardia.
- A primary lesion may swell and the lesions of secondary Syphilis may increase or appear for the first time.

- Reassure the client that if this occurs, it is normal and they should drink fluids and take oral analgesics if needed.

F. Follow-up:

1. Inform the client of referral to Disease Intervention Specialist (DIS) for sex partner notification in order to prevent further spread of the disease.
2. Refer to regional DIS for partner notification follow-up if unknown to DIS.
3. Re-evaluate with Syphilis testing and symptom assessment at 6 and 12 months.
4. If client is pregnant, advise client of need to be re-evaluated with Syphilis test and symptom assessment monthly until delivery.
5. If client is HIV seropositive, re-evaluate with Syphilis testing and symptom assessment at 3, 6, 9, 12 and 24 months after treatment.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SYPHILIS PROTOCOLS

DATE DEVELOPED: 5/00
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/22

I. POLICY:

The professional staff of the Division of Public Health Services Family Planning/ STD Program will assess and evaluate clients in the clinical settings for Syphilis. Syphilis is a systemic disease caused by T. Pallidum bacterium. Clients who have Syphilis may seek treatment for signs or symptoms of primary infection (i.e., ulcer or chancre at the infection site), secondary infection (i.e., manifestations that include but are not limited to, skin rash, mucocutaneous lesions, and lymphadenopathy), or tertiary infection (i.e., cardiac, ophthalmic, auditory abnormalities, and gummatous lesions).

II. PURPOSE:

The clinical staff of the Division of Public Health Services will screen, evaluate and treat clients with a diagnosis of Syphilis. Clients will be treated based on the current guidelines of the North Carolina Sexually Transmitted Diseases Public Health Program – Centers for Disease Control and Prevention Division of Sexually Transmitted Diseases Prevention and DIS intervention. Detection, counseling, education and care for sexually transmitted infections that pose a significant threat to the public improve the health of people in Rockingham County and North Carolina. The main purpose is to prevent and control the spread of Syphilis. Clients may be counseled in all clinical settings on the prevention and spread of Syphilis.

III. GUIDELINES:

A. Management guidelines and reporting laws:

1. Guidance is generally provided by Regional DIS. Treat all contacts to a known case of Syphilis or a suspected case of Syphilis, and other high-risk individuals, prophylacticly with 2.4 million units of Benzathine penicillin (Bicillin-LA) at the time of initial visit. Other high-risk individuals include persons who report a history of Syphilis symptoms, persons reporting having sex with someone with Syphilis symptoms, and persons repeatedly having unprotected sex with high-risk partners (i.e. partners met on the internet, sex for money, sex while using drugs).

2. Complete a full history and physical exam (including oral and anal examination) for signs and symptoms of Syphilis.
3. Clients tested for Syphilis should be concurrently tested for HIV. Clients tested for HIV should be tested for Syphilis. All clients diagnosed with Syphilis must have an HIV test.
4. All early cases are to be reported, by phone, within 24 hours to the local Health Director or designee (per NCGS10A NCAC 41A.0101).
5. Laboratories will report all Serologic Tests for Syphilis (STS) titers of 1:8 and above, by phone or electronic lab report (ELR), within 24 hours (per NCGS 10A NCAC 41A.0102).
6. Local health department will report all cases, by phone, to the HIV/STD Prevention and Care Branch Regional Offices (per NCGS10A NCAC 41A.0103).
7. Refer clients for free Twinrix© (hepatitis A and B) vaccine as indicated. Clients presenting to STD program for screening found to be eligible for vaccinations are educated, counseled and referred to onsite immunization clinic for vaccination.

B. Protocol For Evaluation of Person Exposed to Syphilis:

1. Persons sexually exposed to a client with early Syphilis should be evaluated clinically and serologically. If the exposure occurred within the previous 90 days, the person may be infected yet seronegative and therefore should be presumptively treated. (It may be advisable to presumptively treat persons exposed more than 90 days previously if serologic test result is not immediately available and follow-up is uncertain.) Clients who have other STDs may also have been exposed to Syphilis and are counseled to have a serologic test for Syphilis and HIV.
2. Symptoms of Syphilis:

    a. Most men and women with Syphilis notice symptoms; however, many do not. A sore called a chancre is the first sign of primary Syphilis. The sore may appear on the penis, scrotum, labia, inside the vagina, or on other parts of the body such as fingers, mouth, throat, breasts, and anus. If not treated, the chancre will go away after 1-8 weeks; however, even though the chancre goes away, the person remains infected.
    b. After approximately 6-8 weeks, secondary symptoms may appear. Symptoms include: flu-like feelings (fever, aches, poor appetite, sore throat, headache, or swollen glands), hair loss, condylomata lata, body rash that may occur all over the body, in the mouth, on the palms of the hands, or

the soles of the feet, or on the sex organs. Typically, symptoms occur first around the sex organs.

3. Screen for other STDs: see "STD-2 Clinical Protocols for STD Client Exam".
4. Serologic test: Direct fluorescent antibody tests on lesions or tissue are the definitive methods for diagnosing early Syphilis. A non-treponemal serology test (such as RPR with RPR titer if reactive as performed at NCSLPH), plus a confirmed qualitative treponemal test (TrepSure, TrepCheck, TrepID, etc.) are diagnostic for Syphilis. Non-treponemal antibody titers do tend to correlate with disease activity, usually rising with new infection and falling after treatment. Non-treponemal antibody test results should be reported quantitatively and titered out to a final end point rather than reported as greater than an arbitrary cutoff (e.g., > 1:512). With regard to changes in non-treponemal test results, a fourfold change in titers is equivalent to a two-dilution change---e.g., from 1:16 to 1:4, or from 1:8 to 1:32.

   NOTE: If a lesion is present and testing is available, lesion exudate/tissue specimen may be completed for Darkfield processing. Sequential serologic tests in individual patients should be performed using the same testing method, (VDRL or RPR), preferably by the same laboratory.

C. Protocols For Treatment of Primary and Secondary Syphilis and Early Latent Syphilis of Less Than One Year's Duration (Early non-primary, non-secondary):

Penicillin Therapy: Long acting Benzathine Penicillin G (Bicillin L-A) is the preferred drug for treating adult clients with early Syphilis (including pregnant women and people with HIV infection). For clients with penicillin allergy, skin testing with desensitization, if necessary, is optimal. These clients will be referred to DIS and/or a primary care physician of choice.

1. Recommended Treatment Regimen:

   Benzathine Penicillin G (Bicillin L-A) 2.4 million units IM (either as a single 2.4 mu injection or split into two (2) 1.2 mu* injections given in each buttock).

   *Preferred method of delivery for patient comfort.

2. Alternative Regiment for Penicillin-Allergic Clients (non-pregnant):

   See Sexually Transmitted Infections Guidelines, 2021.

Doxycycline 100 mg PO BID x 14 days, or

Tetracycline 500 mg PO QID x 14 days.

Penicillin-allergic clients who cannot tolerate Doxycycline should have their allergy confirmed. Doxycycline and Tetracycline are equivalent therapies.

There is less clinical experience with Doxycycline, but compliance is better. In clients who cannot tolerate Doxycycline or Tetracycline:

- If follow-up or compliance cannot be ensured, the client should have skin testing for Penicillin allergy and be desensitized if necessary.

3. Pregnant Client: Benzathine Penicillin G (Bicillin L-A) is the recommended therapy with documented efficacy for Syphilis during pregnancy. Pregnant women with Syphilis in any stage who report Penicillin allergy should be desensitized and treated with Penicillin. Regional DIS and/or OBGYN medical provider coordinate Penicillin desensitization facilitation.

   Benzathine Penicillin G (Bicillin L-A) 2.4 million units IM (either as a single 2.4 mu injection or split into two (2) 1.2 mu* injections given in each buttock).

   *Preferred method of delivery for patient comfort.

4. Treatment of Client's With Positive HIV Infection:

   Persons with HIV infection who have primary or secondary Syphilis should be treated as those without HIV infection.

   Benzathine Penicillin G (Bicillin L-A) 2.4 million units IM (either as a single 2.4 mu injection or split into two (2) 1.2 mu* injections given in each buttock).

   *Preferred method of delivery for patient comfort.

   There are no alternative treatments for positive HIV clients. If allergic to Penicillin, these clients must be desensitized and treated with Penicillin.

5. Injections of long acting Benzathine Penicillin G (Bicillin L-A) are given at the Division of Public Health Services and some primary care physicians offices.

NOTE: Treatment administered at the Division of Public Health Services will be provided based on recommendations of Regional DIS and/or per order of the Advanced Practice Provider (APP) or medical director.

6. Refer to APP or medical director for any of the following:

   Female Client

   a. Symptoms of PID:
      - acute abdominal pain/uterine tenderness
      - abnormal cervical mucopurulent discharge or cervical friability
      - irregular uterine bleeding
      - oral temperature $\geq 101.0^{o}$ (F)
      - cervical motion tenderness
      - adnexal tenderness
      - abundant WBCs on wet mount

   b. IUD's – for evaluation regarding need for removal, if indicated.
   c. Symptoms of disseminated Gonococcal infection:
      - inflammation of joint
      - skin lesions
   d. Severe lymphadenopathy
   e. Symptoms of ectopic pregnancy
   f. Any other problem assessed by the RN requiring consultation.

7. Refer to APP or medical director for any of the following:

   Male Client

   a. Swollen and/or tender testicles with or without fever
   b. Testicular nodule
   c. Symptoms of disseminated Gonococcal infections:
      - inflammation of joint
      - skin lesions
   d. Severe lymphadenopathy

8. Very few clients develop Neurosyphilis if recommended treatment regimens are followed. If clinical signs and symptoms of neurologic involvement exist such as optic, auditory, cranial, nerve, tabes dorsalis (loss of coordination or movement), Meningovascular Syphilis, or general paralysis of the insane, client is referred immediately to private provider for further evaluation. Other symptoms of latent Syphilis can be gumma, which are nodular ulcerative lesions on the skin, mucous membranes, skeletal system,

and viscera; cardiovascular Syphilis manifests with aortitis, aneurysm, or aortic regurgitation; or iritis, choroid retinitis, and leukoplakia may occur. With any of these signs/symptoms present, the client is referred immediately to a private physician.

D. Protocols for Diagnosis and Treatment of Latent Syphilis (Latent Syphilis of unknown duration or Late Latent Syphilis)

Latent Syphilis is not transmitted sexually with treatment objective of treating persons in this disease stage being to prevent medical complications of Syphilis

1. All clients with suspicion of Latent Syphilis should have a thorough clinical examination of all accessible mucosal surfaces to evaluate for mucosal lesion (primary or secondary Syphilis) before making a Latent Syphilis diagnosis. Physical examination should include the oral cavity, perianal area, perineum, rectum, and genitals (vagina and cervix for women; scrotum, penis, and underneath the foreskin for uncircumcised men). See STD-2 Clinical Protocols for STD Client Exam".

2. Penicillin Therapy: Long acting Benzathine Penicillin G (Bicillin L-A) is the preferred drug for treating adult clients with Latent Syphilis (including pregnant women and people with HIV infection).

   Recommended Treatment Regimen:

   a. Benzathine Penicillin G (Bicillin L-A) 7.2 million units total, administered as 3 doses of 2.4 million units IM (either as a single 2.4 mu injection or split into two (2) 1.2 mu* injections given in each buttock) given one week apart for 3 consecutive weeks.

      *Preferred method of delivery for patient comfort.

   b. Treatment administered at the Division of Public Health Services will be provided based on recommendations of Regional DIS and/or per order of the APP or Medical Director.

3. Alternative Regimen for Penicillin-Allergic Clients (non-pregnant): See Sexually Transmitted Infections Treatment Guidelines, 2021.

   a. Doxycycline 100 mg PO BID x 28 days, or
   b. Tetracycline 500 mg PO QID x 28 days.

4. Pregnant Clients:
   Benzathine Penicillin G (Bicillin L-A) 7.2 million units administered as 3 doses of 2.4 million units IM (either as a single 2.4 mu injection or split into two (2) 1.2 mu* injections given in each buttock) given one week apart for 3 consecutive weeks.

   *Preferred method of delivery for patient comfort.

   If the pregnant client is allergic to Penicillin, there are no alternative regimens to treat positive Syphilis. Those allergic to Penicillin should be treated with Penicillin after desensitization.

5. Pregnant women are followed up by private MD after treatment for Syphilis is completed as recommended by DIS.

6. Clients who are HIV Positive:
   Benzathine Penicillin G (Bicillin L-A) 7.2 million units, administered as 3 doses of 2.4 million units IM (either as a single 2.4 mu injection or split into two (2) 1.2 mu* injections given in each buttock) given one week apart for 3 consecutive weeks.

   *Preferred method of delivery for patient comfort.

   There are no alternative treatments for positive HIV clients; desensitization should be done and then client should be treated with Benzathine Penicillin G.

E. DIS Intervention for Syphilis:

   Counseling Regarding Positive Syphilis Test Results

1. The usual practice at the Division of Public Health Services is to pre-arrange for a DIS to be present at the time of the client's scheduled return visit for notification/contact investigation regarding positive test results; the DIS gives the client the positive Syphilis test result, and the DIS then provides case management, any needed referrals, and serves as a resource agency for the positive Syphilis clients.

2. The DIS provides counseling and education:

   a. Confirms the client's test results by identifying information
   b. DIS will check client's past history for Syphilis
   c. Advises client of positive Syphilis results
   d. Explains Syphilis diagnosis and positive Syphilis test results
   e. Assesses client's emotional state; allows the client time to react to the positive test result

f. Gives additional information:

- Benefits of early medical intervention, current medical treatments that are available
- Advise client that he/she can transmit the disease to others and must practice risk reduction
- Explain healthy behaviors

g. Assesses the client's understanding of information shared about Syphilis.

h. Explain that the Division of Public Health Services has to report the positive Syphilis test results to the State, but does not report to family, employer, etc. Disease reporting to the state is done through the North Carolina Electronic Disease Surveillance System (NC EDSS); this is done by DIS.

i. If DIS is not aware of the diagnosis, inform the client that a DIS will provide management and follow-up with client regarding treatment and care.

j. Review North Carolina Syphilis Control Measures and penalties if violated.

k. Stress condom use and offer condoms.

F. Instructions to Client:

1. Avoid sexual contact until client and sexual partner(s) have completed medication.
2. Counsel all clients regarding the correct use of condoms as well as client-specific counseling and literature about personal risk reduction behavior.
3. Caution female clients taking oral contraceptives to use back-up method for birth control while on antibiotic(s) therapy and for 7 days after completion. (Client should not be sexually active until all sexual partners are evaluated and treated, abstain from sex for 7 days after single dose treatment and/or until 7 days after all oral medication is completed.)
4. Caution clients to not get pregnant while taking Doxycycline. If female is taking Doxycycline and not pregnant, she should avoid pregnancy during her current menstrual cycle while taking Doxycycline for 14/28 days.
5. Counsel clients regarding the importance of early re-evaluation if symptoms persist or recur.
6. Counsel clients about risk of HIV infection and recommend HIV testing.
7. If abdominal pain or fever develops, call the clinic at the Division of Public Health Services. This is very important if the client has an IUD.

8. If the client is using a diaphragm, it needs to be disinfected per manufacturer's instructions.
9. Women who are pregnant should not be treated with tetracyclines.
10. Syphilis has been associated with an increased risk of acquiring HIV. Clients diagnosed with Syphilis should be tested for HIV.
11. Doxycycline may cause side effects such as nausea, abdominal pain, vomiting, diarrhea, rash, urticaria, photosensitivity, and increased pigmentation.

Counsel the client regarding the possibility of developing the Jarisch-Herxheimer reaction within 24 hours of treatment for Syphilis.

- Symptoms may include fever, malaise, headache, musculoskeletal pain, nausea, and tachycardia.
- A primary lesion may swell and the lesions of secondary Syphilis may increase or appear for the first time.
- Reassure the client that if this occurs, it is normal and they should drink fluids and take oral analgesics if needed.
- Advise the client to contact their primary care provider or the STD clinic if Jarisch-Herxheimer reaction occurs.

G. Follow-Up:

1. Inform the client of referral to Disease Intervention Specialist (DIS) for sex partner notification in order to prevent further spread of the disease.
2. Refer to regional DIS for partner notification follow-up if unknown to DIS.
3. Re-evaluate Early Syphilis (Primary, Secondary, Early Latent Syphilis) with testing and symptom assessment at 6 and 12 months. Re-evaluate Late Latent Syphilis or Latent Syphilis of Unknown Duration with testing and symptom assessment at 6, 12 and 24 months.
4. If client is pregnant, advise client of need to follow up OBGYN medical provider for Syphilis testing and symptom assessment monthly until delivery.
5. If client is HIV seropositive, advise client of need to follow up with Infectious Disease medical provider for Syphilis testing and symptom assessment at 3, 6, 9, 12 and 24 months after treatment.

Treatment failures can occur with any regimen. If non-treponemal antibody titers have not declined fourfold by 6 months in primary, secondary, or early latent Syphilis, or if signs or symptoms persist and reinfection has been ruled out, clients should be referred to private physician of choice for evaluation and be retreated appropriately. Follow-up for Latent Syphilis is

to be done at 6, 12, and 24 months with a fourfold decline in titer expected at 12-24 months.

HIV infected clients should have follow-up including serologic testing at 3, 6, 9, 12, and 24 months with a fourfold decline in the titer expected at 6-12 months after therapy. In addition to the above guidelines for 3, 6, 9, 12, and 24 months, any client with a fourfold increase in titer at any time should be referred to private physician of choice for evaluation and be treated with the Neurosyphilis regimen, unless reinfection can be established as the cause of the increased titer. Latent Syphilis in HIV-infected clients requires follow-up at 6, 12, 18, and 24 months after therapy. A fourfold decline in titer is expected at 12-24 months.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PELVIC INFLAMMATORY DISEASE PROTOCOLS

DATE DEVELOPED: 4/93
DATE REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
DATE REVISED: 6/15; 6/16; 6/17; 6/22

I. POLICY:

A. The Advanced Practice Provider (APP) of the Division of Public Health Services will screen and evaluate all clients presenting to the clinical setting with symptoms of pelvic inflammatory disease.

B. Definition: Pelvic inflammatory disease (PID) is a general description of inflammation caused by infection in the upper female genital tract. Although infection of the fallopian tubes (salpingitis) is the most common and characteristic component of (PID), endometrium (endometritis), ovaries (oophoritis), uterine wall (myometritis), and broad ligament or uterine serosa (parametritis) may also be present. PID is an acute process unless unusual organisms, such as tuberculosis or actinomycetes, are involved.

C. Etiology: The vast majority of the cases of PID are the result of the ascending migration of organisms from the vagina and cervix. Infection spreads along the mucosal surface of the endometrium to the fallopian tubes. Infection and inflammation may then spread by transtubal extension to the serosal surfaces of the fallopian tubes or through the fimbriated ends of the tubes. Infection of the ovaries, parametrium, and peritoneal cavity (peritonitis, pelvic abscess) may then result. A portion of PID cases are other micro-organisms that comprise the vaginal flora. Complications of abortion, and other invasive procedures, such as hysterosalpingogram, cervical dilation, and IUD insertion may lead to infections, which can cause PID.

D. Microbiologic organisms that may cause PID:

1. Neisseria Gonorrhoeae
2. Chlamydia Trachomatis
3. Gram positive and negative Anaerobic organisms
4. Aerobic facultative gram positive and negative rods and cocci organisms.

E. Incidence: Despite declining trends, PID is a frequent and serious infection that occurs among women of reproductive age. 1 in 8 women with a history of PID experience difficulties getting pregnant.

II. PURPOSE:

The APP of the Division of Public Health Services will screen, diagnose, and treat clients with Pelvic Inflammatory Disease based on the current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program – Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP). Detection, counseling/ education and care for sexually transmitted infections that pose a significant threat to the public improve the health of people in Rockingham County and North Carolina. These efforts aid the reduction of morbidity and mortality resulting from communicable diseases. Clients diagnosed with Pelvic Inflammatory Disease will be counseled on prevention of the disease.

III. GUIDELINES:

A. Risk Factors:

1. Risk factors for developing PID continue to be important for both clinical management and prevention of PID as STDs are the most common etiological agents for developing PID.
2. Age: The prevalence of PID is highest in women younger than 25 years.
3. Sexual activity: Acute PID is extremely rare in women, who are not sexually active. However, a small fraction of infections may be endogenous in origin. Multiple sexual partners increase a woman's chance of developing PID three-to-four-fold.
4. Menstruation: Acute PID is unusual in women who are pregnant, premenarcheal, or postmenopausal.
5. History of PID: Women who have had one episode of PID are two to three times more likely than other women to have another episode.
6. Contraception: Use of IUDs for contraception pose increased risk for PID in the first month after insertion; oral contraceptives seem to exert a protective effect against PID; barrier contraceptives, such as condoms, diaphragms, and contraceptive jellies and foams, appear to exert significant protective effects against PID.
7. Abortion: The risk of PID following spontaneous abortion is generally quite low. Post abortion PID usually presents as a febrile illness 5-21 days after surgery. Illegal abortion appears to carry a higher risk for PID.
8. Recent instrumentation or genital tract invasive procedures: A history of recent (up to 4 weeks) instrumentation or genital tract procedures is found to increase risks of PID.

9. Douching: There are some data to suggest that douching may increase the risk of PID by disturbing the local cervical defenses and increasing bacterial contamination of the endometrium, tubes, and peritoneal cavity.

B. Differential Diagnosis:

1. Ectopic pregnancy
2. Appendicitis
3. Mesenteric adenitis
4. Pelvic endometriosis
5. Chronic salpingitis and adhesions

C. Symptoms:

1. Symptoms of acute PID most often begin during or immediately after menstruation, regardless of microbilogic etiology.
2. Minimum Criteria: Presumptive treatment for PID should be initiated in sexually active young women and other women at risk for STDs if they are experiencing pelvic or lower abdominal pain, if no cause for the illness other than PID can be identified, and if one of the following minimum clinical criteria are present on pelvic examination: instituted on the basis of the presence of all of the following in the absence of an established cause other than PID.

    a. Uterine tenderness; or
    b. Adnexal tenderness; or
    c. Cervical motion tenderness

3. Additional Criteria: These additional criteria may be used to increase the specificity of the diagnosis:

    a. Oral temperature $\geq 101^0$ F
    b. Abnormal cervical mucopurulent discharge or cervical friability
    c. Elevated erythrocyte sedimentation rate
    d. Elevated C-reactive protein
    e. Laboratory documentation of cervical infection with Gonorrhea or Chlamydia
    f. Abundant WBCs on wet mount

4. The most specific criteria for diagnosing PID include:

    - Endometrial biopsy with histopathologic evidence of endometritis;
    - Transvaginal sonography or magnetic resonance imaging techniques showing thickened, fluid-filled tubes with or without free pelvic fluid or tubo-ovarian complex, or Doppler

studies suggesting pelvic infection (e.g. tubal hyperemia); or
- Laproscopic findings consistent with PID

D. Recommended intramuscular/oral regimen treatment:

1. Ceftriaxone 500 mg (Rocephin) IM in single dose*, plus Doxycycline 100 mg PO BID x 14 days with Metronidazole 500 mg PO BID x 14 days, or
2. Cefoxitin (Mefoxin) 2 gm IM in a single dose plus Probenecid 1 gm PO administered concurrently in a single dose plus Doxycycline 100 mg PO BID x 14 days with Metronidazole 500 mg PO BID x 14 days.
3. Parenteral alternative regimens - see current STD CDC treatment guidelines.

*For persons weighing > 150 kg (~300 lbs.) with documented gonococcal infection, 1 gm of Ceftriaxone should be administered.

E. Instructions to the Client:

1. Provide client-centered STD education, including verbal and written information on the following:

- Sex partners must be notified by the client in order to prevent further spread of disease. Provide client with partner referral cards for all recent (within 60 days) sexual partners.
- Men who have had sexual contact with a woman with PID during the 60 days preceding her onset of symptoms should be evaluated, tested, and presumptively treated for Chlamydia and Gonorrhea, regardless of the etiology of PID or pathogens isolated from the client.
- If client's last exposure was > 60 days before onset of symptoms, refer the most recent sexual partner(s) for exam, testing, and treatment.
- The client should inform sexual partner(s) that they will be examined, tested, and treated at the time of their clinic visit.
- The importance and correct use of condoms.
- The need to abstain from sexual intercourse until completion of all medication regimens and for 7 days after medication completion.
- For female clients, the importance of using a back-up contraceptive while on medication and for 7 days after completion of medication.
- All women who receive a diagnosis of PID should be tested for Gonorrhea, Chlamydia, HIV, and Syphilis.

- The link between HIV and STD infections and the importance of HIV testing
- Caution female clients not to get pregnant while on Doxycycline

2. Teach client about possible medication side effects, such as nausea, vomiting, and headache, abdominal pain, diarrhea, rash, urticaria, photosensitivity, and increased pigmentation.
3. Teach female clients the importance of disinfecting diaphragm per manufacturer's instructions if this is the client's method of contraception.
4. All clients who have received a diagnosis of Chlamydial or Gonococcal PID should be retested 3 months after treatment, regardless of whether their sex partners were treated. If retesting at 3 months is not possible, these women should be retested whenever they next present for medical care in the 12 months following treatment.

F. Follow-up:

Schedule client follow up 24-72 hours after initiation of therapy for PID; women should demonstrate clinical improvement within 3 days of treatment. If no clinical improvement has occurred within 72 hours after outpatient IM/oral therapy, hospitalization, assessment of the antimicrobial regimen, and additional diagnostics are recommended with referral by the APP.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

TITLE: MOLLUSCUM CONTAGIOSUM PROTOCOLS

DATE DEVELOPED: 1/16/03
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/22

I. POLICY:

The Advanced Practice Providers (APPs) of the Division of Public Health Services will assess and/or evaluate clients presenting to the clinical settings with symptoms of Molluscum Contagiosum Virus. Molluscum Contagiosum is a viral infection characterized by mild local irritation. It is caused by a mildly contagious virus that is transmissible by direct and indirect contact. Autoinoculation is also common.

II. PURPOSE:

The APPs of the Division of Public Health Services will evaluate, diagnose, and treat clients with Molluscum Contagiosum virus as indicated. APPs follow the current guidelines of the North Carolina Sexually Transmitted Diseases (NC STD) Public Health Program – Centers for Disease Control and Prevention (CDC) Division of Sexually Transmitted Diseases Prevention (DSTDP). Detection, counseling/education and care for sexually transmitted infections that pose a significant threat to the public improve the health of people in Rockingham County and North Carolina. These efforts aid the reduction of morbidity and mortality resulting from communicable diseases.

The client will be provided education on the disease, mode of transmission and prevention of spread to other persons.

III. GUIDELINES:

History: Molluscum contagiosum is an infection caused by a poxvirus (molluscum contagiosum virus). The result of the infection is usually a benign, mild skin disease characterized by lesions (growths) that may appear anywhere on the body. Within 6-12 months, Molluscum contagiosum typically resolves without scarring but may take as long as 4 years.

A. The client will usually present with the complaint of small bumps.

B. Physical examination:

1. The lesions, known as Mollusca, are small, raised, and usually white, pink, or flesh-colored with a dimple or pit in the center. They often have a pearly appearance. They're usually smooth and firm. In

most people, the lesions range from about the size of a pinhead to as large as a pencil eraser (2 to 5 millimeters in diameter). They may become itchy, sore, red, and/or swollen.

2. Necrosis and infarction of the overlying skin may produce umbilication through which a grit-like, milky material can be expressed.
3. Mollusca may occur anywhere on the body including the face, neck, arms, legs, abdomen, and genital area, alone or in groups. The lesions are rarely found on the palms of the hands or the soles of the feet.

C. Investigative procedures: Diagnosis is made by the appearance of the lesion.

D. Management/Treatment Options:

1. Because molluscum contagiosum is self-limited in healthy individuals, treatment may be unnecessary. Issues such as lesion visibility, underlying atopic disease, and the desire to prevent transmission may prompt therapy**.** Molluscum usually disappears spontaneously within 6-12 months without treatment and without leaving scars. Some lesions may remain for up to 4 years.
2. Treatment for molluscum is usually recommended if lesions are in the genital area (on or near the penis, vulva, vagina, or anus). Lesions are found in these areas should be evaluated as there is increased risk of other disease spread by sexual contact.
3. Physical removal of lesions may include cryotherapy (freezing the lesion with liquid nitrogen) with referral to dermatology for this therapy.
4. Curettage (the piercing of the core and scraping of caseous or cheesy material) of the lesion or laser therapy with referral to dermatology for this therapy.
5. Podophyllotoxin (Condylox) cream (0.5%) by prescription with instruction for use per the APP, is a reliable home therapy for men but not recommended for pregnant women (presumed toxicity to the fetus). Each lesion must be treated individually as the therapeutic effect is localized.
6. Aldara (Imiquimod) cream 5% by prescription with instruction for use per the APP. Client is instructed to apply a thin film of cream to lesions, 3 times a week and wash off in 6-10 hours after application: Monday, Wednesday, and Friday or Tuesday, Thursday and Saturday

E. Instruct Client:

- Wash hands with soap and water before and after using the medicine.
- Use one or two packets for each dose as directed by your doctor.
- Apply a thin layer to the affected lesions of the skin just before bedtime. Rub it in gently.
- Allow the medicine to stay on the treated skin for 6 to 10 hours. Do not take a bath, swim, or get the treated area wet during this time.
- After the right amount of time has passed, wash the treated area with mild soap and water.
- Men who are not circumcised and are treating lesions under the foreskin should retract the foreskin and clean the area daily.
- Do not bandage or otherwise wrap the skin being treated, unless directed to do so by your doctor. Materials that are not airtight, such as cotton gauze or cotton underwear, may be used if needed.
- Throw out any unused cream from the single-dose packet.
- Client is instructed to stick to dosing schedule: in most clients, lesions disappear in 8-12 weeks. Many people see reddening of the lesions during treatment, which is usually not painful.

F. Prevention Education

- Following good hygiene habits
- Good handwashing habits
- Don't scratch or pick at Molluscum lesions
- Keep Molluscum lesions covered
- Be careful during sports activities
- Avoid sharing infection: Do not shave or have electrolysis on areas with lesions. Don't share personal items such as unwashed clothes, hair brushes, wrist watches, and bar soap with others. If you have lesions on or near the penis, vulva, vagina, or anus, avoid sexual activities until advised by a health care provider.

G. Follow-up:

Client to return to clinic post treatment of lesions or as needed for any complications. Client presentation for evaluation of complaint of bumps may be diagnosed as other viral skin conditions. Upon request, clients are provided with community resources for care including follow-up at the Division of Public Health Services Adult Primary Care Clinic.

Clients may be seen in the STD Program Clinic by the APPs experienced in this care after initial diagnosis with this service provided as Adult Primary Care per Adult Primary Care guidelines and applicable fee schedule.

IV. REFERENCES:

Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: COMMUNITY OUTREACH FOR STD SURVEILLANCE AND EDUCATION

DATE DEVELOPED: 6/12
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/22

I. POLICY:

The Division of Public Health Services will establish and maintain active communication with local healthcare providers regarding sexually transmitted diseases (STDs) and provide surveillance, education, and required control measures to prevent the spread of STDs in the community. The health education program shall organize outreach programs for the public and/or medical community to increase awareness of STD issues as needed.

II. PURPOSE:

To establish best practice guidelines for community outreach to healthcare providers and the public.

III. DEFINITIONS:

STD- Sexually Transmitted Disease
Surveillance- the collection and analysis of data about an infectious disease as reported by health care providers in the routine practice of medical care.

IV. APPLICABLE LAW, RULES AND REFERENCES:

10A NCAC 41A .0101 REPORTABLE DISEASES AND CONDITIONS

V. RESPONSIBLE PERSONS:

1. Healthcare providers are responsible for reporting the following STDs to the Division of Public Health Services within the time period specified after the disease or condition is reasonably suspected to exist:

    a. human immunodeficiency virus (HIV) seropositive; within 24 hours
    b. Syphilis within 24 hours
    c. acquired immune deficiency syndrome (AIDS); within 24 hours
    d. chancroid; 24 hours
    e. chlamydial infection (laboratory confirmed); 7 days
    f. gonorrhea; 24 hours
    g. hepatitis B (acute); 24 hours
    h. hepatitis B carriage; 7 days
    i. nongonococcal urethritis; 7 days
    j. pelvic inflammatory disease; 7 days
    k. granuloma inguinale, 24 hours

2. The Division of Public Health Services will ensure the following:

    a. Seropositive HIV tests are reported to the CDB regional office within 24 hours of receipt of a positive report.
    b. Investigation of STD reports within 30 days of receiving notification of a reportable STD.
    c. Investigation and reporting to the NC Division of Public Health (DPH) via the North Carolina Electronic Disease Surveillance System (NC EDSS) is complete.

VI. GUIDELINES:

1. *Interacting with community providers-*

    a. The Division of Public Health Services communicates with community providers of STD services as needed (news releases or revised information from the State or CDC) to provide information about reporting requirements, reportable STDs, the importance of reporting and the impact on public health prevention efforts, and STD treatment guidelines.
    b. Communicable disease (CD) staff is available 24/7 to respond to concerns or receive STD reports from the community, hospitals, health care providers, schools, and/or other agencies.
    c. CD staff is available by work telephone number/voicemail, cellular phone number/voicemail, and/or e-mail.
    d. Medical providers and hospital infection control nurses are sent an annual (or as needed) list of health department after hours and emergency contact names and numbers.
    e. CD staff has multiple means of communicating available such as NC EDSS, email, secure fax, and telephone with other health care providers, hospitals, other state and county public health professionals, and other key agencies.

2. *Investigation and surveillance-*

    a. STD disease investigations begin by contacting the physician of record for disease specific information and treatment. If there is no physician of record, or if the physician of record does not respond to requests for information promptly, or if the physician is not able to provide complete disease investigation information, then the individual may be contacted.
    b. CD staff have access to the North Carolina Electronic Disease Surveillance System (NC EDSS) for receiving laboratory reports, for reporting of STDs or other communicable disease events, and may retrieve system reports that identify and monitor providers who test for STDs, report significant STD morbidity and/or serve high-risk populations.

c. The Division of Public Health Services provides quarterly and/or annual feedback via CD/STD statistical reports to the Board of Health and Human Services, medical providers, and Epi-team staff.

3. STD Education and Outreach-

STD prevention requires changing the behaviors that place people at risk for infection. Prevention and control efforts must include effective, sustained education and outreach programs. The goal of these programs is to reduce the risk of individuals becoming infected with STDs or, if already infected, infecting others. The Division of Public Health Services provides information to the community through its website located at www.facebook.com or www.rockinghamcounty.dhhs.org. Below are descriptions of other outreach services:

a. **STD Clinic-** provides consultation, education, screening, diagnosis, treatment, follow-up, referral of patients with STDs when referral is indicated, and provides STD prevention measures/free condoms as requested.

b. **Health Education-** works to increase the knowledge through education of individuals, organizations and the community to prevent STDs and to promote general sexual health by providing free educational materials, conducting presentations, workshops, in-services, and health fairs for communities and professional partners in the community. Health education staff provide high school outreach activities by providing STD education through the Student Health Centers, distributing annual newsletters and community alerts, using surveillance data for planning, identifying and targeting high risk populations or high morbidity areas, and identifying and including other community partners in the outreach planning process (i.e., *The Community Health Assessment)*.

c. **Communicable Disease Control-** responds to requests for STD-related data from both public and private agencies and prepares reports for the State and local agencies. CD staff provides office visits and direct interaction to enhance communication and visibility as requested or indicated (errors in reporting or lack of reporting).

d. **Division of Public Health facility-** Pamphlets, brochures, and STD specific information/agency directory of services are routinely distributed throughout the health department and community, and are available upon request.

VII. REFERENCE PLANS & POLICIES:

The Division of Public Health Services' STD policies and Standing Orders Centers for Disease Control and Prevention MMWR, Recommendations and Reports/Vol.70/No.4/July 23, 2021 Sexually Transmitted Infections Treatment Guidelines, 2021 @ www.cdc.gov

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

WIC - CLINIC
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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: WIC VENDOR APPLICATION

DATE DEVELOPED: 6/10
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17

I. POLICY:

The Division of Public Health Services WIC Program will accept applications from local vendors to become an authorized WIC Vendor on a quarterly basis. Applications will be accepted in March, June, September, and December. Applications may be accepted in other months at the discretion of the WIC Program Director.

II. PURPOSE:

The purpose of the policy is to ensure that local vendors interested in becoming authorized WIC vendors are treated fairly and their application can be process on a timely basis. This policy will also ensure that the WIC Program can accept applications and schedule trainings without interrupting regular scheduled clinic services.

III. GUIDELINES:

A. Vendors interested in becoming an authorized WIC Program Vendor will be prescreened on the phone by the WIC Director or Lead Worker.

B. Vendors will be given an appointment to receive an application and other required paperwork and applicant training.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: WIC TEXT/DIGITAL PLATFORM

DATE DEVELOPED: 3/22
REVIEWED: 6/22; 6/23; 6/24
REVISED: 6/24

I. POLICY:

Local agency staff will use texting/digital platforms within the WIC Program Guideline, as outlined in the WIC Program Manual, in a way that provides secure and accurate information and maintains the protection of participant protected health information.

II. PURPOSE:

To guide clear expectations for the secure communication between staff and applicants/participants in addition to use in the provision of WIC Program Services.

III. GUIDELINES:

A. In order to protect health information, the WIC Program will only utilize the Teletask Platform integrated with Crossroads MIS system for text communication. The WIC Program will only use agency issued technology and user accounts. Staff will NOT use personal devices or personal user accounts for communicating with program applicants/participants.

B. Staff will ask all applicants/participants if they want to enroll in the two-way texting appointment reminder system. Staff will explain that standard messaging and data rates may apply and that the platform used by the WIC Program is secure but that we cannot guarantee the security of their actual device. Participants will be notified of the option to opt out at any time by replying STOP, and that by opting out they will no longer receive appointment reminders by text.

C. Staff will limit texting/digital communications to scheduling, appointment reminders, and/or invitation to nutrition education classes. Staff will NOT conduct appointments by text. Message text will be straightforward and will use proper punctuations, spaces, and limit abbreviations to those in the

approved abbreviations list. No icons or images will be utilized (i.e., emojis).

D. **The breastfeeding peer counselor may use two-way texting to introduce herself to clients she is unable to contact, as well as send breastfeeding education or resource links to clients. The client will approve text, email or phone interaction and specify which is preferred when signing up for the peer counselor program. Any complex or in-depth discussion with the peer counselor will occur by phone or in person.**

E. Any situation that requires a more complex or nuanced discussion must happen in person or over the phone. Staff will document in the Crossroads Care Plan for conversations beyond basic appointment confirmation and rescheduling. Local agency staff will seek guidance from WIC Director when questions about whether documentation is needed. Local agency staff will err on the side to document in the care plan.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MEDICAL NUTRITION THERAPY

DATE DEVELOPED: 7/01
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/22

I. POLICY:

Medical Nutrition Therapy (MNT) will be provided to clients of the Division of Public Health Services.

II. PURPOSE:

To provide comprehensive nutrition intervention to eligible participants who have chronic, episodic, or acute conditions where nutrition is a critical component in managing the condition, including preventable conditions in which nutrition/diet is the primary therapy.

III. GUIDELINES:

A. Medical Nutrition Therapy must be provided by:

- A Licensed Dietitian/Nutritionist, licensed by the North Carolina Board of Dietetics/Nutrition, or
- A Registered Dietitian, registered with the Commission on Dietetic Registration

B. Eligibility Guidelines:

1. Women receiving MNT must:

   a. Be pregnant or postpartum. Postpartum status includes the time after delivery up to the end of the month in which the 60th postpartum day occurs.
   b. Have one or more of the medical/nutritional indicators listed in Section C.

2. Children and Adolescents receiving MNT must:

   a. Be under the age of 21.
   b. Have a medical/nutrition related health problem listed in Section C.

C. Guidelines for Referrals:

1. Pregnant and Postpartum women may be referred for MNT if they have one or more of the following high-risk indicators:

   a. Conditions which impact on length of gestation or birth weight, where nutrition is an underlying cause, such as severe anemia (Hgb < 10 GM/DL or Hct <30%), preconceptionally underweight (BMI <19.8), inadequate weight gain during pregnancy, fetal growth restriction, adolescent under the age of 16, multiple fetuses, substance abuse (alcohol or drugs).
   b. Metabolic disorders, such as diabetes, maternal PKU or other inborn errors of metabolism, thyroid dysfunctions.
   c. Chronic medical conditions, such as cancer, heart disease, hypertension, inflammatory bowel disease, malabsorption syndromes, renal disease.
   d. Chronic or prolonged infections which have a nutritional treatment component, such as HIV, AIDS, or hepatitis.
   e. Autoimmune diseases or nutritional significance, such as systemic lupus erythematosus.
   f. Eating disorders such as severe pica, anorexia nervosa, or bulimia nervosa.

2. Children and Adolescents may be referred for MNT for any medical condition requiring nutritional intervention, including but not limited to:

   a. Inappropriate growth/weight gain such as inadequate weight gain, inappropriate weight loss, underweight, obesity, inadequate linear growth or short stature.
   b. Nutritional anemia.
   c. Eating or feeding disorders that result in a medical condition such as failure to thrive.
   d. Physical conditions which impact on growth and feeding such as very low birth weight, necrotizing entercolitis, cleft palate, cerebral palsy and neural tube defects.
   e. Chronic or prolonged infections which have a nutritional treatment component such as HIV or hepatitis.
   f. Genetic conditions that impact on growth and feeding such as Cystic Fibrosis, Prader-Willi Syndrome and Down Syndrome.
   g. Chronic medical conditions such as cancer, chronic or congenital cardiac disease, hypertension, hyperlipidemia,

gastrointestinal diseases, liver disease, pulmonary disease, malabsorption syndromes, renal disease, significant food allergies and diseases of the immune system.

h. Metabolic disorders such as inborn errors of metabolism (e.g., PKU, galactosemia) and endocrine disorders (e.g., Diabetes).

3. All individuals receiving MNT that are categorically eligible for the WIC Program and are not currently participating **must** be referred to the WIC Program for routine nutrition education and food supplements.

4. All WIC participants referred for MNT must have had the two nutrition education contacts required by the WIC Program prior to billing Medicaid for MNT.

5. The qualified Nutritionist providing MNT should also refer clients to Care Management for High Risk Pregnancies (CMHRP), Care Management for At Risk Children (CMARC), or other assistance programs for which they might be eligible.

6. Referrals for MNT can come from within the Division or from outside providers, including but not limited to, private physicians, student health centers, and mental health providers.

D. Documentation of Services:

1. An electronic medical record must be maintained for each person receiving Medicaid reimbursed MNT.

2. All clients receiving MNT from the Division of Public Health Services will have an electronic medical record opened.

3. Documentation must include date of service, presenting problem, summary of required nutrition service components, duration of visit (e.g. 15 minutes, 30 minutes, etc.), and electronic signature of qualified Licensed Dietitian/Nutritionist or Registered Dietitian providing the services.

4. Records must be maintained in accordance with Standard 5 of the Records Disposition Schedule, and must be accessible during Division of Maternal and Child Health Program reviews and Division of Medical Assistance record audits.

5. For both women and children, the nutrition service must include:

    a. A review of medical management and an evaluation of medical and psychosocial history, and treatment plan, as they affect nutrition interventions.
    b. A diagnostic nutritional assessment which may include:
        - Review and interpretation of pertinent laboratory and anthropometric data;
        - Analysis of dietary and nutrient intake;
        - Assessment of feeding skills and methods.
    c. Development of an individualized nutrition care plan, which may include:
        - Recommendations for nutrient and calorie modifications;
        - Calculation of a therapeutic diet for disease states such as diabetes, renal disease, and PKU; or
        - Referral to other care providers.
    d. Intensive counseling on nutritional/dietary management of nutrition-related conditions.
    e. Consultation with primary care provider.
    f. Education on reading food labels.

E. Billing for Medical Nutrition Therapy:

1. Billing for Medical Nutrition Therapy will be done in accordance with Medicaid Billing guidelines the Division of Public Health Services follows.

2. Non-Medicaid clients will be billed on a sliding fee scale.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ADOLESCENT NUTRITION

DATE DEVELOPED: 9/04
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17

I. POLICY:

Adolescent nutrition counseling will be provided to clients from birth to 21 years of age.

II. PURPOSE:

Nutrition education is provided to promote healthy lifestyles and disease prevention, as well as to help treat/manage acute or chronic medical conditions.

III. GUIDELINES:

A. Referrals:

1. Referrals can be made from within the health department, from student health centers, private physicians, parents or guardians or from the individual needing nutrition counseling.

2. Referrals can be made for any medical/nutritional conditions requiring nutritional intervention, including but not limited to:

   a. Inappropriate growth/weight gain such as inadequate weight gain, inappropriate weight loss, underweight, obesity, inadequate linear growth or short stature.
   b. Nutritional anemia.
   c. Physical conditions which impact on growth and feeding such as very low birth weight, necrotizing entercolitis, cleft palate, cerebral palsy and neural tube defects.
   d. Chronic or prolonged infections which have a nutritional treatment component such as HIV or hepatitis.
   e. Genetic conditions that affect growth and feeding such as Cystic Fibrosis, Prader-Willi Syndrome and Down Syndrome.
   f. Chronic medical conditions such as diabetes, cancer, chronic or congenital cardiac disease, hypertension, hyperlipidemia, gastrointestinal diseases, liver disease, pulmonary disease, malabsorption syndromes, renal disease, significant food allergies and diseases of the immune system.

B. Documentation of services:

1. An electronic medical record must be opened for all clients receiving nutrition counseling from the Division of Public Health Services.

2. Documentation will include date of service, presenting problem, summary of nutrition services and electronic signature of qualified nutritionist providing the service.

3. Records must be maintained in accordance with Standard 5 of the Records Disposition Schedule, and must be accessible during Medical Record audits.

4. The nutrition service may include:

   a. A review of medical management and an evaluation of medical and psychosocial history, and treatment plan, as they affect nutrition interventions.
   b. A diagnostic nutritional assessment which may include:
      - Review and interpretation of pertinent laboratory and anthropometric data;
      - Analysis of dietary and nutrient intake;
      - Assessment of feeding skills and methods.

   c. Development of an individualized nutrition care plan, which may include:
      - Recommendations for nutrient and calorie modifications;
      - Calculation of a therapeutic diet for disease states such as diabetes, renal disease, and PKU; or
      - Referral to other care providers.

   d. Intensive counseling on nutritional/dietary management of nutrition-related conditions.
   e. Consultation with primary care provider.
   f. Education on reading food labels.

C. Billing for Adolescent Nutrition:

1. Billing for Adolescent Nutrition will be done in accordance with Medicaid Billing guidelines the Division of Public Health Services follows.

2. Non-Medicaid clients will be billed on a sliding fee scale.

3. Nutrition services must be provided by a Licensed Dietitian/ Nutritionist or Registered Dietitian to be a billable service.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: ADULT HEALTH NUTRITION

DATE DEVELOPED: 6/3/97
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/17; 6/22

I. POLICY:

Adult Health nutrition services will be provided to all persons ≥ 21 years of age in Rockingham County.

II. PURPOSE:

Nutrition education is provided for the promotion of healthy lifestyles and disease prevention, as well as helping to treat/manage acute or chronic medical conditions.

III. GUIDELINES:

A. Individual nutrition counseling will be provided in a face-to-face setting by a qualified nutritionist.

B. Adults may be referred for Adult Health Nutrition services for any medical condition requiring nutritional intervention, including but not limited to:

1. Unexplained weight loss or underweight
2. Overweight/obesity
3. Metabolic disorders, such as diabetes, thyroid dysfunctions, or other inborn errors of metabolism
4. Chronic medical conditions, such as cancer, heart disease, hypertension, inflammatory bowel diseases, malabsorption syndromes, or renal disease
5. Chronic or prolonged infections, which have a nutritional treatment component, such as HIV, AIDS, or hepatitis
6. Autoimmune diseases of nutritional significance, such as systemic lupus erythematosus
7. Eating disorders such as severe pica, anorexia nervosa, bulimia nervosa, or binge eating disorder.

C. The qualified nutritionist can make referrals to other assistance programs that the client may be eligible for, such as Pregnancy Care Management (PCM) or the Food Stamp program.

D. Documentation of Services:

1. All clients receiving Adult Nutrition services from the Division of Public Health Services will have an electronic medical record opened.

2. Documentation must include date of service, presenting problem, summary of nutrition services and electronic signature of qualified nutritionist providing the service.
3. Records must be maintained in accordance with Standard 5 of the Records Disposition Schedule, and must be accessible during Division of Maternal and Child Health Program reviews and Division of Medical Assistance record audits.

E. Service Components:

The nutrition evaluation may include the following:

1. A review of medical management and an evaluation of medical and psychosocial history, and treatment plan, as they affect nutrition interventions.
2. A diagnostic nutritional assessment which may include –
   - Review and interpretation of pertinent laboratory and anthropometric data;
   - Analysis of dietary and nutrient intake;
   - Determination of drug-nutrient interactions;
   - Assessment of feeding skills and methods
3. Development of an individualized nutrition care plan which may include –
   - Recommendations for nutrient and calorie modifications;
   - Calculations of a therapeutic diet for disease states such as diabetes, renal disease, and PKU;
   - Referral to other care providers
4. Intensive counseling on nutritional/dietary management for nutrition-related medical conditions
5. Consultation with Primary Care Provider
6. Education on reading food labels

F. Billing for Adult Health Nutrition:

1. Billing for Adult Health Nutrition will be done in accordance with Medicaid Billing guidelines of the Division of Public Health Services.
2. Non-Medicaid clients will be billed on a sliding fee scale
3. Nutrition service must be provided by a Licensed Dietitian/ Nutritionist or Registered Dietitian to be a billable service.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: WIC LOW RISK NUTRITION EDUCATION FOR MANAGEMENT SUPPORT STAFF

DATE DEVELOPED: 10/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/17; 6/20; 6/23

I. POLICY:

The WIC Management Support Staff will provide nutrition education "mini lessons" for low risk children scheduled by a Nutritionist to complete this type of lesson as their follow up.

II. PURPOSE:

The nutrition class will provide a quick "mini lesson" on a specific nutrition topic**,** anticipatory guidance or public health related topic for low risk children, which will allow nutritionists more time for counseling high risk children.

III. GUIDELINES:

A. A nutritionist will be responsible for the following:

1. Developing the "mini lessons";
2. Securing educational handouts;
3. Training the Management Support Staff on teaching the lessons and documenting the lesson in the Crossroads computer system;
4. Reviewing the scheduling process with the rest of the nutrition staff.

B. A Nutritionist will train Management Support Staff on teaching the lessons provided by WIC CNSS Staff and review documentation in the Crossroads computer system.

C. The WIC CNSS (State Office) Staff create and update the wichealth.org website and lessons as needed.

D. If this type of lesson is scheduled, parents/guardians of low risk children may do an online class or choose to do a mini lesson in the WIC office or over the phone with WIC Staff to fulfill their second contact between their initial certification and mid-year assessment. This type of lesson can also fulfill their third contact between the mid-year assessment and subsequent certifications.

E. Low risk postpartum women and infants may complete online lessons in lieu of coming in for the 3-month follow up after initial certification after delivery. They will complete the lessons in wichealth.org on "Taking Care of You after Baby Arrives" and "Feeding Your Infant on Solid Foods".

1. The CPA/Nutritionist decides which postpartum/infant dyads are eligible for online lessons. They must fall in low risk category for eligibility.

2. Wichealth.org links into Crossroads in real time and will update lesson when completed. A designated Management Support Staff will monitor participants needing benefits.

3. Designated Management Support Staff will monitor WIC Gmail and delete duplicate certificates as needed.

4. Management Support Staff will manually enter completed lessons if real time update does not occur. Complete benefit issuance once correct online lesson manually entered into Topic Status.

F. <u>Weaning Class</u>

1. The Management Support Staff will follow the Weaning Class lesson plan to educate parents on introduction of liquids from a sip cup for infants 6 months or older by using the "Help Me Be Healthy: 6-12 Months" (Teach Me to Drink From a Cup section) or the parent/guardian will complete "Baby's First Cup" online between their 5-7 month visit and their scheduled 8-11 month visit.

2. Target audience is infants 8-11 months old.

3. The objective is to encourage and teach older infants to learn to drink from a sip cup.

4. The Nutritionist determines which infants to schedule for the class.

G. <u>Documenting Low-Risk Follow-Up</u>

1. Locate family under the Dashboard appointment schedule or by completing a family search.

2. Go to Care Plan and click on Nutrition Education. Scroll down to Topic Status and open by clicking on arrow.

2. To update scheduled topics as completed, Management Support Staff will locate the topic "Wean To Cup" or Baby's First Cup",

click on pencil to edit and update to today's date with the status completed then hit update to complete entry.

4. Crossroads has linked with wichealth.org so scheduled topics should automatically update as completed in real time. Management Support Staff will verify completion in the Nutrition Education topic status then issue eligible benefits and schedule for future appointment. Update alert to show current follow up appointment.

5. Certificate copies are not required since wichealth.org updates Crossroads patient accounts in real time. A designated Management Support Staff will monitor email and keep updated and cleaned out as needed.

6. Use WICHEALTH support on the wichealth.org website and WIC Gmail to verify online lessons that fail to link in real time.

F. Toddler Feeding Class (TFC)

1. The Management Support Staff will follow the Choking Prevention Class guidelines to educate the parent/caretaker on foods that can be a choking hazard to young children. They will also include education on bottle weaning and proper juice/beverage intake.

2. The Toddler Feeding Class handouts can include the following:

   a. Help Me Be Healthy: 1-1 ½ years (for food safety information);
   b. Healthy Drinks WIC mini lesson;
   c. First Teeth WIC mini lesson

3. Target audience will be children at least ≥ 12 months old who have completed a certification at 9-12 months old.

4. The objective is to be able to select foods that are safe and nutritious for young children, ensure bottle weaning and drinking age-appropriate beverages and amounts.

5. A Nutritionist determines which children to schedule for the TFC class.

6. The Management Support Staff will document "TFC" under General Low Risk topic heading under Nutrition Education Topic Status in Crossroads system. Management Support Staff just needs to hit the pencil to edit the date for today and change status to complete. In the comments section type "TFC". Management Support Staff will need to select General Low-Risk Topic under Nutrition Education

Topics if not already scheduled in Topic Status then follow steps for updating education topic in comments section.

G. WIC Nutrition Mini Lessons

1. The Management Support Staff will follow the recommendation listed by the Nutritionist who scheduled the mini lesson.

2. A Nutritionist provides training for the Management Support Staff on each new mini lessons as they are added and will keep required documentation in the mini lesson training book.

3. Target audience will be children aged 12 months – 5 years old.

4. A Nutritionist schedules children for the nutrition class mini lesson.

5. The Management Support Staff will document the mini lesson in the Crossroads computer system as follows:

   a. Locate family under dashboard appointment schedule or by completing a family search.
   b. Go to Care Plan and click on Nutrition Education. Go to Topic Status and open by clicking arrow.
   c. For scheduled topics, Management Support Staff just needs to click the pencil to edit to today's date and update to status of complete. In comments section, type the mini lesson topic completed (i.e., Fruits & Veg: The Easy Way).
   d. For topics not yet listed in the Topic Status, Management Support Staff will locate the appropriate class in the Nutrition Education list, mark as Individual Contact and check box of appropriate client completing class, then hit complete. Update comments section with typed mini lesson topic.

6. Parents/guardians of low risk children may choose to do their follow up class online at the wichealth.org website. Wichealth.org now updates online lessons in the Crossroads system in real time. A log of Completion certificates is not required since they update into Crossroads in real time. A designated Management Support Staff will monitor completed classes and issue benefits for those participants. The designated staff will monitor and update the WIC Gmail as needed to delete certificates not needed.

7. If wichealth.org does not link a lesson into Crossroads, Management Support Staff manually verifies the lesson through WICHEALTH support on the wichealth.org website. After manually adding the lesson into the Nutrition Education Topic Status, issue benefits and schedule needed follow up visit.

8. Management Support Staff will complete follow up mini lesson by phone if participant/guardian is unable to complete online lesson or would prefer to complete the visit by phone instead on online.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: BREASTFEEDING PEER COUNSELOR PROGRAM

DATE DEVELOPED: 4/10
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 9/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 9/19; 6/22; 6/23; 6/24

I. POLICY:

The Breastfeeding Peer Counselor will provide information, encouragement and support to prenatal women and new mothers.

II. PURPOSE:

To increase the number of women who breastfeed by providing accurate information and to increase the duration of breastfeeding by providing support.

III. GUIDELINES:

A. Consultation and Referral Support for Breastfeeding Peer Counselor

The breastfeeding peer counselor program manager/breastfeeding coordinator is the designated lactation specialist from whom the breastfeeding peer counselor seeks consultation and/or refers participants.

The breastfeeding peer counselor program manager and peer counselor will discuss cases as needed, and the peer counselor will consult and ask for help immediately if there is a problem beyond her scope of practice. The program manager will also provide names and numbers of other lactation specialists to be called in her absence.

The program manager will fax or call the participants primary health care provider if there is a concern over the baby's weight gain or feedings.

B. Breastfeeding Peer Counselor Accessibility to WIC Participants

The peer counselor will see participants at the Division of Public Health Services during local agency hours. She will make telephone calls, have face-to-face individual sessions, group support sessions, **use Teletask,** write emails**, and use MyNCWIC**. The peer counselor will work 20 hours per week. Breastfeeding peer counselor services will be offered to all pregnant and breastfeeding postpartum women enrolled in the WIC Program. The participant will select preferred contact methods for the breastfeeding peer counselor contacts on the Breastfeeding Peer Counselor Program Letter of Agreement.

Once participant is enrolled into the breastfeeding peer counselor program, the Breastfeeding Peer Counselor Program Letter of Agreement will be given to the breastfeeding peer counselor within two business days of enrollment. The breastfeeding peer counselor program manager will monitor her caseload.

Prenatal contacts will be made within 30 days of assignment to the breastfeeding peer counselor and an additional contact at two weeks prior to expected delivery date. Postpartum contacts will be made every 2-3 days in the first week post delivery and weekly for the remainder of the first month. Participants will be contacted monthly until 6 months. Thereafter, they will be contacted as needed until one year postpartum.

C. Documentation of Breastfeeding Peer Counselor Services

The Breastfeeding Peer Counselor Program Letter of Agreement form is scanned into Crossroads. The peer counselor will document enrollment of participant by creating a family alert in Crossroads. All contacts are documented in the breastfeeding counselor contact section in Crossroads. When the peer counselor discontinues services to a participant the family alert will be removed in Crossroads.

Each breastfeeding peer counselor contact with a participant must be documented, and the peer counselor must report the number and type of contacts made on a monthly basis. The breastfeeding peer counselor program manager should use this information for evaluating the monthly activities of the breastfeeding peer counselor and for managing the caseload assignments.

D. Breastfeeding Peer Counselor Phone Line

The breastfeeding peer counselor telephone number with answering machine will be provided to WIC patients to answer questions, help with problems, or make appropriate referrals.

The breastfeeding peer counselor will be responsible for checking the telephone line to answer questions, help with problems, or make appropriate referrals during scheduled work hours, five days a week. Patients calling with problems will be followed-up within 24-48 hours and until problem is resolved. If patients call during unscheduled work hours and need immediate assistance the telephone message will refer them to their medical provider.

The breastfeeding peer counselor will do monthly checks on the phone line to assure the line and messaging system is working properly.

E. Breastfeed Peer Counselor Emails, **Teletask, and MyNCWIC**

The breastfeeding peer counselor will have access to the Rockingham County WIC email, **Teletask, and MyNCWIC** to send breastfeeding resources to participants from the North Carolina WIC program breastfeeding resource list **or as another form to contact participant if not able to reach by phone**.

F. Breastfeed Peer Counselor Unavailable

If the breastfeeding peer counselor is not available to provide service to participants, a letter will be mailed to each participant. The letter will inform the participant that they can contact the WIC office and talk with a nutritionist for any breastfeeding questions or services needed.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: WIC PROGRAM IMMUMIZATION SCREENING AND REFERRAL

DATE DEVELOPED: 3/06
REVIEWED: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/15; 6/16; 6/17; 6/23

I. POLICY:

The Division of Public Health Services WIC Program will screen the immunization status of infants and children (up to 24 months of age) participating in the WIC Program and make appropriate referrals based on the findings of the screening.

II. PURPOSE:

The purpose of the screening is to identify children under age two who are at risk for under-immunization.

III. GUIDELINES:

A. The nutritionist will be responsible for screening the immunization status of infants/children (up to 24 months of age) and documenting the findings and action taken in the Health Information, Care Plan Summary or Referral sections in Crossroads.

B. Screening occurs at the initial certification visit, mid-year assessment and subsequent certification visit for infants and children up to 24 months old.

C. Chapter 6, Section 6 of the NC WIC Program Manual on minimum screening requirements provides guidance to assess overall immunization status.

D. If the immunization status is up to date, it is documented in the Health Information section in Crossroads. No further action is required.

E. If the immunization status is not up to date, the nutritionist will provide information on the recommended immunization schedule appropriate for the age of the infant/child and refer the infant/child to his/her medical provider for immunizations. If the infant/child does not have a medical provider, he/she will be referred to the Division of Public Health Services.

F. If the client's immunization status is unknown due to lack of documentation in the North Carolina Immunization Registry, the nutritionist will provide information on the recommended immunization schedule appropriate for

the current age of the infant/child and refer the infant/child for immunization services to his/her health care provider and request the parent/caretaker to bring the immunization record to the next certification/ mid-certification visit. If they do not have a health care provider, they will be referred to the Division of Public Health Services.

G. The nutritionist will document when immunization status is not up to date or is unknown and when referrals to immunization services are made.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: WIC VOTER REGISTRATION DOCUMENT MANAGEMENT

DATE DEVELOPED: 04/16
REVIEWED: 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services WIC Program Outreach Clerk is responsible for the management of the "National Voter Registration Act Agency Transmittal Form" and retention of the "Board of Elections Voter Registration Preference Forms". In her absence, the Lead Worker will perform these duties.

II. PURPOSE:

The National Voter Registration Act (NVRA) of 1993 requires a number of benefit programs, including the WIC Program, to offer program applicants/participants/ parents/guardians/caretakers the opportunity to register to vote. The WIC Program Outreach Clerk must ensure the voter registration applications collected by the WIC Program along with a National Voter Registration Act Transmittal form are delivered within five business days of acceptance to the Board of Election. The WIC Program must have each applicants/participants/parents/guardians/caretakers complete a Voter Registration Preference Form documenting that they have been offered the opportunity to register to vote. The Outreach Clerk ensures that these forms are file properly for audits and dispose of according to the state record retention guidelines.

III. GUIDELINES:

A. The Outreach Clerk will collect all the WIC Program Voter Registration Applications on Fridays and send to the Rockingham Board of Election along with a NVRA Agency Transmittal Form. The applications and transmittal form will be sent to the Rockingham County Board of Election via interagency mail.

B. The Outreach Clerk will collect all of the WIC Program Board of Elections Voter Registration Preference Forms on Fridays. They will be filed by month and year. Disposal of forms will be done according to the state record retention guidelines.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: PROVIDING SERVICES FOR WALK-IN CLIENTS

DATE DEVELOPED: 8/16
REVIEWED: 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health Services WIC Program will provide services for walk-in clients as the schedule permits.

II. PURPOSE:

The purpose of this policy is to ensure walk-in clients are served within the required processing standards guidelines of the North Carolina WIC Program and to ensure clients that have transportation problems or other difficulties coming at a scheduled time may receive services.

III. GUIDELINES:

A. Walk-in clients will be served between the hours of 9 AM - 4:00 PM when the schedule permits.

B. If the program is working with limited staff or if there is not enough time to provide the service, the client will be scheduled an appointment within processing standards.

C. Walk-in clients will be advised that clients with scheduled appointments will be served first.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF PUBLIC HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: SEPARATION OF DUTIES

DATE DEVELOPED: 12/16
REVIEWED: 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/21

I. POLICY:

There must be separation of duties among local staff so that the same person does not complete both income eligibility determination and medical or nutritional risk eligibility determination for the same client.

II. PURPOSE:

To preserve the integrity of the certification and food benefit issuance processes and to minimize the potential for staff fraud and program abuse, federal regulations require the implementation of policies and procedures that prevent conflict of interest or the appearance of conflict by local agency staff.

III. GUIDELINES:

A. The clerical staff will be responsible for completing the income eligibility of clients but if necessary, the nutritionist can complete this task.

B. The nutritionist will be responsible for completing the medical and or nutrition eligibility of clients.

C. Both clerical and nutrition staff are responsible for issuing food benefits to clients.

D. If there are times when separation of duties are not possible and a nutritionist must complete both the income eligibility and the medical and or nutrition eligibility of a client, the following guidelines must be followed:

1. Staff completing the certification must complete the first five columns of the Separation of Duties Log.
2. The WIC Director or designee (someone other than the certifier) will complete a record review and complete the last five columns of the Separation of Duties Log within 14 calendar days of the certification.
3. The completed Separation of Duties Log will be kept in a note book in the clerical staff office which is kept secured. Staff will have access to the notebook when needed.

4. The logs will be maintained in consecutive order by date and available for review during the state agency monitoring visit and local agency self-review.
5. The WIC Director or designee must contact the agency's Regional Nutrition consultant immediately if the local agency review of the Separation of duties Log suggests irregularities in the WIC certification activity.

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF PUBLIC HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: WIC PROGRAM DIASTER POLICY

DATE DEVELOPED: 6/18
REVIEWED: 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
REVISED: 6/21; 6/24

I. POLICY:

The Division of Public Health WIC Program will follow procedures and guidelines established by the Rockingham County Health and Humans Services, Rockingham County WIC Program and the NC WIC Program in the event of an emergency.

II. PURPOSE:

The purpose of the policy is to ensure that the WIC Program continues to serve the public with minimum interruptions in the event of an emergency.

III. GUIDELINES:

A. Emergencies will be assessed by the WIC Director or designee.

B. Major disruption of services will be reported to the proper authorities immediately including but not limited to the Health Director and Regional Consultant or their designee. This may include local disasters or disruption in the computer system.

C. The WIC Director will be the employee designated as the contact person in time of a disaster. There is a "Chain of Command List" in the absence of the WIC Director. This "list" will be updated annually or as needed.

D. Staff will be directed by the WIC Director or designee as to what contingency plan they should use to provide services to the public during an emergency.

E. When a disaster situation is predicted, clients will be called in advance to rearrange time of appointments if necessary. Benefits will be issued early if possible. Certification will be extended by one (1) month if possible. Clients are also instructed to check the county website for information on hours of operation and other information. Local vendors will be contacted regarding changes in their business hours.

F. If there is a disruption in the standard operation hours of the county, this information is broadcast on the local news and the county switchboard has a recording of the county revised operating hours. The information is also posted on the county website. If possible, the information will be posted on the WIC Program face book page.

G. In the event the Local Agency is unable to access the Crossroads system and the duration of interruption is uncertain, the WIC Program Business Continuity Plan will be put into effect. The forms used for this plan are stored in the management support office. All of the staff are equipped with laptops and are able to complete certifications remotely. Currently staff are not able to print documents remotely or to sign for benefits remotely.

H. **The Local Agency will follow the NC WIC Manual policy contingency plan to return to normal operation of services once the Crossroads system has been restored.**

Rev/di

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: MEDICAL LACTATION SERVICES

DATE DEVELOPED: 2/23
REVIEWED: 6/23; 6/24
REVISED:

I. POLICY:

Medical Lactation Services (MLS) will be provided to clients of the Division of Public Health Services.

II. PURPOSE:

To provide comprehensive lactation intervention to eligible participants who are in need of lactation support or guidance as a critical component in lactation management, as well as to help treat/manage lactation-related conditions.

III. GUIDELINES:

A. Medical Lactation Services must be provided by an International Board Certified Lactation Consultant (IBCLC).

B. Eligibility Guidelines:

1. Lactating individuals receiving medical lactation services must:

- Be a lactating individual or an individual inducing lactation.
- Have a high-risk factor listed in Section C.

2. Human milk fed infants receiving medical lactation services must:

- Be under the age of one year.
- Have a high-risk factor listed in Section C.

C. Guidelines for Referrals:

1. Lactating individuals may be referred for MLS if they have one or more of the following high-risk factors:

a. Painful breasts, nipples
b. Breast or nipple abnormality
c. Mastitis
d. Perception of or actual inadequate human milk supply
e. Lack of social or environmental support
f. Cultural practices that affect the ability to human milk feed
g. Introduction of feeding via bottle or other route that may affect human milk feeding

h. Conditions associated with a diagnosis or treatment (e.g., mastitis, candidiasis, engorgement, history of breast surgery)
i. Reports or observations of:

- Small amount of human milk when pumping
- Lack of confidence in ability to human milk feed
- Does not hear infant swallowing
- Concerns regarding mother's choice to human milk feed/lack of support
- Insufficient knowledge of breastfeeding or infant satiety/hunger signals
- Lack of facilities or accommodations at place of employment or in community for human milk feeding
- Feeding via bottle or other route

2. Infants may be referred for MLS if they have one or more of the following high-risk factors:

a. Has latch-on difficulties
b. Is premature
c. Is a multiple birth
d. Jaundice
e. Poor sucking ability
f. Oral pain or aversions
g. Has a special need (such as Down Syndrome, cleft lips or palate or other congenital anomoly affecting feeding)
h. Malnutrition/malabsorption
i. Lethargy, sleepiness
j. Irritability
k. Swallowing difficulty
l. Introduction of food via bottle or other route that may affect human milk feeding
m. Dehydration and difficulty with weight gain
n. Fewer than reference standard, e.g., six wet diapers in 24 hours
o. Any weight loss or inadequate weight gain
p. Frenulum abnormality
q. Vomiting or diarrhea
r. Hunger, lack of satiety after feeding
s. Conditions associated with a diagnosis or treatment, e.g., thrush, premature birth, malabsorption, infection
t. The mother-infant dyad needs assistance in the continuation of breastfeeding
u. Reports or observations of:

- Coughing
- Crying, latching on and off, pounding on breasts

- Decreased feeding frequency/duration, early cessation of feeding, and/or feeding resistance
- Lethargy

3. All individuals receiving MLS that are categorically eligible for the WIC Program and are not currently participating **must** be referred to the WIC Program for routine nutrition education and food supplements.

4. All WIC participants referred for MLS must have had the two nutrition education contacts required by the WIC Program prior to billing Medicaid for MLS.

5. The qualified lactation consultant providing MLS should also refer clients to Care Management for High Risk Pregnancies (CMHRP), Care Management for At Risk Children (CMARC), or other assistance programs for which they might be eligible.

6. Referrals for MLS can come from within the Division or from outside providers, including but not limited to, private physicians, student health centers, and mental health providers.

D. Documentation of Services

1. An electronic medical record must be maintained for each person receiving Medicaid reimbursed MLS.

2. All clients receiving MLS from the Division of Public Health Services will have an electronic medical record opened.

3. Documentation must include:

a. Date of service
b. Summary of required lactation service components including:
- Review of infant medical management, evaluation of medical and psychosocial history and treatment plan
- Diagnostic lactation assessment must consist of all of the following:

- A history of infant feeding, sleep, and activity patterns
- Urine and stool output
- Infant weight; weight cannot be conducted via telephone and audio/video
- Skin color, condition, turgor, moisture and temperature
- Alertness

- Review and consultation with ordering provider of pertinent infant laboratory and radiologic data
- Observation of feeding with pre- and post-weights, if indicated by clinical judgement
- Referral of infant for additional testing or medical treatment if indicated
- Communication of all pertinent lactation assessment details to the infant's primary care provider.

c. Duration of visit (e.g. 15 minutes, 30 minutes, etc.)
d. Electronic signature of qualified International Board Certified Lactation Consultant providing the services.

4. Records must be maintained in accordance with Standard 5 of the Records Disposition Schedule, and must be accessible during Division of Maternal and Child Health Program reviews and Division of Medical Assistance record audits.

5. For both lactating individuals and individuals inducing lactation, the lactation service must include:

a. A review of medical management and an evaluation of medical and psychosocial history, and treatment plan, as they affect lactation interventions.
b. A diagnostic lactation assessment which may include:

- Review and interpretation of anthropometric data
- Analysis of human milk feeding sessions
- Assessment of human milk feeding skills

c. Development of an individualized lactation care plan, which may include:

- Recommendations for human milk feeding modifications
- Referral to other care providers

d. Intensive counseling on human milk feeding
e. Consultation with primary care provider
f. Education on human milk expression and storage

E. Billing for Lactation Consultant Services:

1. Billing for Lactation Consultant Services will be done in accordance with Medicaid Billing guidelines the Division of Public Health Services follows.
2. Non-Medicaid clients will be billed on a sliding fee scale.

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
POLICY

TITLE: BREASTFEEDING CONSULTATION AND REFERRALS

DATE DEVELOPED: 10/22
REVIEWED: 6/23; 6/24
REVISED:

I. POLICY:

The Division of Public Health WIC Program will maintain breastfeeding promotion and support to WIC clients.

II. PURPOSE:

The purpose of this policy is to clearly outline WIC staff roles in breastfeeding promotion and support and identify process for referrals.

III. GUIDELINES:

See table below for appropriate breastfeeding support and referral process.

DS:di

Breastfeeding Consultation and Referral Policy
RCDHHS
WIC

WIC Staff Roles	Situation	Point of Contact	Contact Information	Contact Method
Peer Counselor (PC)	Normal breastfeeding questions or problems that do not resolve in 24 hours	DBE	Dana Simmons *dsimmons@co.rockingham.nc.us* 336-342-8199 WIC Program	In- person, phone or email
	Complex breastfeeding problems	DBE	Dana Simmons dsimmons@co.rockingham.nc.us 336-342-8199 WIC Program	In- person, phone or email
	Nutrition or food package	CPA	336-342-8200 WIC Program	In- person, phone
	Medical concerns for mother or infant	CPA/DBE	336-342-8200 WIC Program	In- person, phone
Competent Professional Authority (CPA)	Refer/enroll pregnant and breastfeeding WIC participants to the Breastfeeding Peer Counselor Program	PC	Vacant 336-342-8200 WIC Program	In-person, phone
	Peer to peer breastfeeding education and support	PC	Vacant 336-342-8200 WIC Program	In-person, phone
	Complex breastfeeding problems	DBE	Dana Simmons dsimmons@co.rockingham.nc.us 336-342-8199 WIC Program	In-person, phone or email
	Medical concerns for mother or infants	Healthcare provider	Medical Provider List	Phone, Fax
WIC designated breastfeeding expert (DBE)	Resolved breastfeeding problems	PC	Vacant 336-342-8200 WIC Program	In-person, phone, email
	Peer to peer breastfeeding education and support	PC	Vacant 336-342-8200	In-Person, Phone, Email

Breastfeeding Consultation and Referral Policy
RCDHHS
WIC

WIC Staff Roles	Situation	Point of Contact	Contact Information	Contact Method
WIC designated breastfeeding expert (DBE) continued			WIC Program	
	Complex breastfeeding beyond the scope of the DBE	Community Resources (IBCLC), Regional Lactation Trainer and/or healthcare provider	Jackie Davis- WIC IBCLC jmdavis@co.rockingham.nc.us 336-342-8201 Hannah Edens, IBCLC, RLC EDENSH@ecu.edu NC WIC LATCH Director 336-339-0361 Medical Provider List	Phone, Email, Fax
	Nutrition and food package	CPA	336-342-8200 WIC Program	In- person, phone
	Medical concerns for mother or infant	Healthcare provider	Medical Provider List	Phone, Fax
Other WIC Staff	All breastfeeding questions and concerns	PC	Vacant 336-342-8200 WIC Program	In-Person, Phone, Email
	Peer to peer breastfeeding education and support	PC	Vacant 336-342-8200 WIC Program	In-Person, Phone, Email
	Nutrition and food package	CPA	336-342-8200 WIC Program	In- person, phone
	Medical concerns for the pregnant or breastfeeding participant or infant	CPA/DBE	336-342-8200 WIC Program	In- person, phone

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

WIC/Adult Health/Adolescent/Health Promotion Nutritionist

Competency Skills Checklist

		SUBJECT	DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The WIC/Adult Health/Adolescent/Health Promotion Nutritionist applies theoretical concepts in practice.						
	B.	The WIC/Adult Health/Adolescent/Health Promotion Nutritionist systematically collects data that is comprehensive and accurate.						
	C.	The WIC/Adult Health/Adolescent/Health Promotion Nutritionist evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	D.	The WIC/Adult Health/Adolescent/Health Promotion Nutritionist participates in peer review and program audits to assure quality of services.						
	E.	The WIC/Adult Health/Adolescent/Health Promotion Nutritionist collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	F.	The WIC/Adult Health/Adolescent/Health Promotion Nutritionist reports to clinic as assigned in a timely manner.						
	G.	The WIC/Adult Health/Adolescent/Health Promotion Nutritionist introduces self to client.						
	H.	The WIC/Adult Health/Adolescent/Health Promotion Nutritionist uses appropriate communication techniques to make client comfortable, addresses client concerns and telephone calls with dignity and respect.						
	I.	The WIC/Adult Health/Adolescent/Health Promotion Nutritionist performs the work-up of clients, accurately documenting results of information obtained.						
	J.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist facilitates the flow of clients through the clinic to promote health care accessibility, decrease wait time, and provide high quality services.						
	K.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist demonstrates familiarity with the client record and chart composition.						
	L.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	M.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist demonstrates support of agency by involvement in community activities.						
	N.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist uses chain of command for problem resolution.						

	O.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist adheres to appropriate dress and grooming.						
	P.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist maintains a reliable attendance record.						
	Q.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist safely and accurately assists other staff during procedures.						
	R.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist provides appropriate nutrition education/counseling						
	S.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist provides appropriate nutrition education material						
	T.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist determines appropriate time and action for follow up visit						
	U.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist makes appropriate referrals						
	V.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist evaluates lab and anthropometric data						
	W.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist calculates out Body Mass Index						
	X.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist obtains weights and height/length for infants, children and women.						
	Y.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist completes appropriate documentation Cross Roads and Patagonia.						
	Z.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist corrects errors in documentation						
	AA	WIC/Adult Health/Adolescent/Health Promotion Nutritionist communicates effectively with clients, medical professionals, social services agencies, vendors, coworkers, etc.						
	BB.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist provides appropriate information to clients about other program services..						
	CC.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist is aware of various county, health department and WIC Program policies.						
	DD	WIC/Adult Health/Adolescent/Health Promotion Nutritionist is aware of various agency policy manuals, where they are located, when to use them.						
	EE.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist completes required reports for health department and WIC Program.						
	FF.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist provides information to clients about the WIC program/formulas/foods.						
	GG.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist completes WIC certification.						
	HH.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist completes appropriate care plans.						
	II.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist assigns appropriate medical/nutritional risk codes.						
	JJ.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist determines appropriate food package.						
	KK	WIC/Adult Health/Adolescent/Health Promotion Nutritionist advises clients of food items they are eligible to receive.						

	LL.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist demonstrates use of electric and manual breast pumps, and other breastfeeding supplies.							
	MM	WIC/Adult Health/Adolescent/Health Promotion Nutritionist completes appropriate forms when issuing breastfeeding supplies.							
	NN.	WIC/Adult Health/Adolescent/Health Promotion Nutritionist uses the following equipment proficiently, safely, and as instructed:							
		1. Phones							
		2. Computers							
		3. Printers							
		4. Security of check stock and toner used to print vouchers							
		5. Copier							
		6. Fax Machine							
		7. Scales							
		8. Height/length Boards							
		Tools							
		9. Precise Plot							
		10. Gestational Wheel							
		Computer System							
		11. Crossroads Computer System							
	OO.	Quality Improvement for Nutrition Staff							
		1. Internal program audit will be conducted.							
		2. Accurately records daily client encounter.							
		3. Documentation must be timely, accurate and precise.							
		4. Maintain continuing education requirements.							
		5. Adheres to agency policies and procedures – reviews annually.							
		6. Reports any changes in client status or program.							
		7. Demonstrates ongoing communication with the client and professional staff.							
		8. Properly completes all required documentation on assigned clients within a timely manner using correct medical terminology.							
		9. Knowledgeable and maintains client rights and confidentiality.							
		10. Implements measures to maintain client confidentiality.							
		11. Demonstrates understanding and implementation of HIPAA compliance.							
II.	**Infection Control Measures:**								
	A.	Handwashing							
		1. Washes hands at least 30 seconds under running water.							
		2. Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.							
		3. Keep fingers pointed down, lower than wrists to prevent contamination of the arms.							
		4. Rinse hands under running water allowing water to flow from the upper arm down over the hands.							
		5. Dry hands thoroughly with a dry paper towel.							
		6. Use a separate paper towel to turn off the faucet.							
		7. Use lotion to prevent drying of the skin.							

		8.	Use gel or foam cleanser to wash hands only until you can use running water.							
	B.	Has attended initial training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.								
	C.	Demonstrates an understanding of and practices universal precautions.								
	D.	Demonstrates an understanding of modes of transmission of bloodborne diseases.								
	E.	Demonstrates knowledge and selection of personal protective equipment.								
	F.	Practices handwashing to prevent spread of disease.								
	G.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.								
III.	**Performance of Duties:**									
	A.	Height/Length								
		1.	Explain procedure							
		2.	Assemble equipment							
		3.	Wash hands							
		4.	Instruct parent on how to assist in positioning of child when height is being obtained							
		5.	Document appropriately							
	B.	Obtains an Accurate Weight								
		1.	Explains the procedure to the parent							
		2.	Assembles equipment a. Baby scales							
		3.	Washes hands							
		4.	Instructs parent how to place child on scales							
		5.	Balances scales							
		6.	For infants 0-12 months, remove all clothing except dry diaper							
		7.	Document findings in the Crossroads EHR.							
		8.	Reports abnormal findings to the referring MD or Advanced Practice Provider (APP)							
IV.	**Skills performance - Body Mechanics:**									
	A.	Sitting:								
		1.	Position buttocks against the back of chair.							
		2.	Place feet flat on floor at 90 degree angle to lower legs.							
		3.	Flexes hip slightly so knees are higher than ischial tuberosities.							
		4.	Flexes lumbar spine slightly.							
		5.	Flexes elbows and places forearms on armrest, if applicable.							
	B.	Standing:								
		1.	Keeps feet parallel 6 inches to 8 inches apart.							
		2.	Places equal weight on both legs.							
		3.	Flexes knees slightly.							
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.							
	C.	Walking:								
		1.	Assumes the correct standing position.							
		2.	Steps forward a comfortable distance with one leg.							
		3.	Tilts the pelvis slightly forward and downward.							
		4.	Touches floor first with heel then ball of foot to toes.							

		5.	Advances the other arm and leg to promote balance.						
	D.	Pulling:							
		1.	Stands close to the object.						
		2.	Places one foot slightly ahead of the other.						
		3.	Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscles.						
	E.	Pushing:							
		1.	Places hands on object and flexes the elbows.						
		2.	Leans into the object by shifting weight from back leg to front leg.						
		3.	Applies smooth continuous pressure.						
	F.	Stooping:							
		1.	Stands with feet 10-13 inches apart.						
		2.	Places one foot slightly ahead of the other.						
		3.	Lowers self by flexing the knees.						
		4.	Places more weight on front foot than back.						
		5.	Keeps upper body straight (does not bend at the waist).						
		6.	Straightens knees keeping the back straight.						
	G.	Lifting and Carrying:							
		1.	Assumes stooping position directly in front of the object.						
		2.	Grasps object and tightens abdominal muscles.						
		3.	Stands up straight by straightening the knees.						
		4.	Carries the object close to the body waist high.						

_____ successfully demonstrates the above criteria in the clinical setting.

_____ _____
Employee Signature & Date Reviewer's Initials & Date

_____ _____
Employee Signature & Date Reviewer's Initials & Date

_____ _____
Employee Signature & Date Reviewer's Initials & Date

Developed: 12/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/15; 6/17

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The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

WIC CLERICAL STAFF

Competency Skills Checklist

		SUBJECT	DATE REVIEWED			REVIEWER'S INITIALS		
I.	**Concepts and Theory:**							
	A.	The WIC Clerical Staff applies theoretical concepts in practice.						
	B.	The WIC Clerical Staff systematically collects data that is comprehensive and accurate.						
	C.	The WIC Clerical Staff evaluates responses of the community, family, and individual interventions in order to determine progress toward goal achievement.						
	D.	The WIC Clerical Staff participates in peer review and program audits to assure quality of services.						
	E.	The WIC Clerical Staff collaborates and works well with other health care providers, other professionals and community representatives displaying courtesy, tact and patience.						
	F.	The WIC Clerical Staff reports to clinic as assigned in a timely manner.						
	G.	The WIC Clerical Staff introduces self to client.						
	H.	The WIC Clerical Staff uses appropriate communication techniques to make client comfortable, addresses client concerns and telephone calls with dignity and respect.						
	I.	The WIC Clerical Staff performs the work-up of clients, accurately documenting results of information obtained.						
	J.	WIC Clerical Staff facilitates the flow of clients through the clinic to promote health care accessibility, decrease wait time, and provide high quality services.						
	K.	WIC Clerical Staff demonstrates familiarity with Crossroads EHR.						
	L.	WIC Clerical Staff effectively works as a team player with flexibility in work assignment and by maintaining a positive and supportive attitude.						
	M.	WIC Clerical Staff demonstrates support of agency by involvement in community activities.						
	N.	WIC Clerical Staff uses chain of command for problem resolution.						
	O.	WIC Clerical Staff adheres to appropriate dress and grooming.						
	P.	WIC Clerical Staff maintains a reliable attendance record.						
	Q.	WIC Clerical Staff safely and accurately assists other staff during procedures.						
	R.	WIC Clerical Staff communicates effectively with clients, medical professionals, social services agencies, vendors, coworkers and etc.						
	S.	WIC Clerical Staff answers phone professionally and in a timely fashion.						
	T.	WIC Clerical Staff provides appropriate information to clients about the WIC Program/formulas/foods and other services available at the Division of Public Health Services.						

	U.	WIC Clerical Staff refers calls if necessary to appropriate staff.								
	V.	WIC Clerical Staff greets clients professionally and assesses their needs.								
	W.	WIC Clerical Staff completes income eligibility on clients.								
	X.	WIC Clerical Staff routes clients through clinic and to nutritionist.								
	Y.	WIC Clerical Staff issues food benefits and obtain signature on electronic signature pad.								
	Z.	WIC Clerical Staff issues farmers market benefits.								
	AA.	WIC Clerical Staff explains how /when/where to use the food benefits.								
	BB.	WIC Clerical Staff gives appropriate educational material to clients.								
	CC.	WIC Clerical Staff makes follow up appointments, give appropriate notices.								
	DD.	WIC Clerical Staff obtains weight and height/length on clients and document appropriately.								
	EE.	WIC Clerical Staff completes vendor management activities.								
	FF.	WIC Clerical Staff completes administrative reports.								
	GG.	WIC Clerical Staff is aware of the various county, health department and state policies.								
	HH.	WIC Clerical Staff is aware of the various agency policy manuals, where they are located and knows when to use them.								
	II.	WIC Clerical Staff completes required reports for health department and WIC Program.								
	JJ.	WIC Clerical Staff uses the following equipment proficiently, safely and as instructed:								
		1. Phones and paging system								
		2. Computers								
		3. Printers								
		4. Security of check stock (paper used to print vouchers) toner (special toner used to print vouchers)								
		5. Copier								
		6. Faxed Machine								
		7. Scales								
		8. Height/length Boards								
		9. Crossroads Computer System								
	KK.	Quality Improvement for WIC Clerical								
		1. Internal program audit will be conducted.								
		2. Documentation must be timely, accurate and precise.								
		3. Maintain continuing education requirements.								
		4. Adheres to agency policies and procedures – reviews annually.								
		5. Reports any changes in client status or program.								
		6. Demonstrates ongoing communication with the client and professional staff.								
		7. Demonstrates ongoing communication with the client and professional staff.								
		8. Properly completes will require documentation on assigned clients within a timely manner using correct medical terminology.								
		9. Knowledgeable and maintains client rights and confidentiality.								
		10. Implements measures to maintain client confidentiality.								

		11.	Demonstrates understanding and implementation of HIPAA compliance.							
II.	**Infection Control Measures:**									
	A.	Handwashing								
		1.	Washes hands at least 30 seconds under running water.							
		2.	Use a firm circular motion to provide friction of the removal of pathogens. Wash debris away from underneath the fingernails. Lather well with antibacterial soap. Prefer not to use bar soap.							
		3.	Keep fingers pointed down, lower than wrists to prevent contamination of the arms.							
		4.	Rinse hands under running water allowing water to flow from the upper arm down over the hands.							
		5.	Dry hands thoroughly with a dry paper towel.							
		6.	Use a separate paper towel to turn off the faucet.							
		7.	Use lotion to prevent drying of the skin.							
		8.	Use gel or foam cleanser to wash hands only until you can use running water.							
	B.	Has attended initial training for OSHA Standards 29 CFR 1910.1030 and annually thereafter.								
	C.	Demonstrates an understanding of and practices universal precautions.								
	D.	Demonstrates an understanding of modes of transmission of bloodborne diseases.								
	E.	Demonstrates knowledge and selection of personal protective equipment.								
	F.	Practices handwashing to prevent spread of disease.								
	G.	Demonstrates knowledge of location, handling, and disposal of PPE, sharps containers, and soiled supplies.								
III.	**Performance of Duties:**									
	A.	Height/Length								
		1.	Explain procedure							
		2.	Assemble equipment							
		3.	Wash hands							
		4.	Instruct parent on how to assist in positioning of child when height is obtained.							
		5.	Document appropriately							
	B.	Obtains an Accurate Weight								
		1.	Explains the procedure to the parent							
		2.	Assembles equipment a. Baby scales							
		3.	Washes hands							
		4.	Instruct parent on how to place child on scales							
		5.	Balances scales							
		6.	For infants 0-12 months, remove all clothing except a dry diaper							
		7.	Document findings in the clinical record.							
IV.	**Skills performance - Body Mechanics:**									
	A.	Sitting:								
		1.	Position buttocks against the back of chair.							
		2.	Place feet flat on floor at 90 degree angle to lower legs.							
		3.	Flexes hip slightly so knees are higher than ischial tuberosities.							
		4.	Flexes lumbar spine slightly.							

		5.	Flexes elbows and places forearms on armrest, if applicable.						
	B.	Standing:							
		1.	Keeps feet parallel 6 inches to 8 inches apart.						
		2.	Places equal weight on both legs.						
		3.	Flexes knees slightly.						
		4.	Retracts buttocks and abdomen, tilts the pelvis back slightly and moves the chest out slightly and shoulders back.						
	C.	Walking:							
		1.	Assumes the correct standing position.						
		2.	Steps forward a comfortable distance with one leg.						
		3.	Tilts the pelvis slightly forward and downward.						
		4.	Touches floor first with heel then ball of foot to toes.						
		5.	Advances the other arm and leg to promote balance.						
	D.	Pulling:							
		1.	Stands close to the object.						
		2.	Places one foot slightly ahead of the other.						
		3.	Tightens the leg muscles and sets the pelvis by simultaneously contracting the abdominal and buttock muscles.						
	E.	Pushing:							
		1.	Places hands on object and flexes the elbows.						
		2.	Leans into the object by shifting weight from back leg to front leg.						
		3.	Applies smooth continuous pressure.						
	F.	Stooping:							
		1.	Stands with feet 10-13 inches apart.						
		2.	Places one foot slightly ahead of the other.						
		3.	Lowers self by flexing the knees.						
		4.	Places more weight on front foot than back.						
		5.	Keeps upper body straight (does not bend at the waist).						
		6.	Straightens knees keeping the back straight.						
	G.	Lifting and Carrying							
		1.	Assumes stooping position directly in front of the object.						
		2.	Grasps object and tightens abdominal muscles.						
		3.	Stands up straight by straightening the knees.						
		4.	Carries the object close to the body waist high.						

_____ successfully demonstrates the above criteria in the clinical setting.

_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date
_____	_____
Employee Signature & Date	Reviewer's Initials & Date

Developed: 12/05
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/15; 6/17

/di

The program supervisor should store this information within the program.

Competencies are to be confirmed/assessed by the supervisor during the initial evaluation and at the time of the annual evaluation.

ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

NUTRITIONIST II ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A.	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B.	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Fire Extinguishers c. Exit signs d. Security e. Tornado plan f. Emergency preparedness • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Vehicle Safety c. Threatening Behavior d. Medical Emergencies • Clients • Employees • Staff training for: Infection Control		
	3. Infection control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease d. Precautions e. Cleaning and Disinfecting, Equipment f. Storing and handling supplies g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB Skin Test		

	• Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management • Electric and Manual Breast Pumps k. Identifying, handling, and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment • Gloves • Impermeable Gown • Vent Mask • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Reporting for child and adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education Requirements		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Council and purpose 2. Call supervisor by 7:00 am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Audits c. Incident Reports d. Client Complaints		
D.	Preceptor Assigned and Receive Nutritionist II Training Checklist		
E.	Orientation period		
F.	Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule – M-F 4. Scope of services and program policy review 5. Client Record/Charting System • Crossroads • Patagonia 6. Documentation tips a. Entries should use good grammar, spelling and punctuation b. Use quotes or the client's own words. Chart factual, accurate, complete and timely c. Document the name of interpreter used		

	d. Use agency approved abbreviations e. Use correct procedure for correcting errors		
	7. Expectations of the Nutritionist II a. Report to clinic as assigned in a timely manner b. Accounts for all work hours through sign-out sheets leave records and time sheets c. Reviews and updates job description annually d. Adheres to dress code – displaying a professional appearance e. Establishes an effective working relationship with others f. Review EMR notes prior to client contact g. Introduce self to client and state purpose h. Use appropriate communication skills i. Assess needs, health history and current status/ document appropriately j. Reliable in following procedures/policies k. Provides services to clients according to standards, program guidelines and collaborates with other disciplines l. Complete WIC certifications, subcerts and prescribe food packages. m. Complete nutrition education and referrals as appropriate n. Provide breastfeeding support and education o. Treats public with courtesy and respect p. Maintains complete confidentiality of client information		
	8. Accreditation process – development, implementation and maintenance		

Employee Signature: _____Date_____

Supervisor Signature: _____ Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.
- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible.

Date Developed: 5/14
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/17

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ROCKINGHAM COUNTY DEPARTMENT
OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

WIC MANAGEMENT SUPPORT STAFF ORIENTATION CHECKLIST

- This tool is utilized mainly by the program supervisor to review with each new employee.
- The topics addressed on this tool may be reviewed by the preceptor, but it is the program supervisor's duty to ensure teaching of these topics and ensuring the new employee's understanding and documentation of compliance.
- The program supervisor should initial and date when topics are addressed and reviewed with each new employee.
- Each entry should have a date and initials indicating review and understanding

	PROCEDURE	DATE REVIEWED	REVIEWER'S INITIALS
A.	Division of Public Health Services 1. Mission, Vision, Goals 2. Location and Review of Policy and Procedures Manuals 3. Confidentiality a. How to maintain privacy b. Penalty for breach of confidentiality		
B.	Review of Policies 1. Agency Safety a. Fire prevention and plan b. Fire Extinguishers c. Exit signs d. Security e. Tornado plan f. Emergency preparedness • Emergency Shelters and Team Assigned		
	2. Personal safety a. Agency Worksite b. Vehicle Safety c. Threatening Behavior d. Medical Emergencies • Clients • Employees • Staff training for: - Infection Control		
	3. Infection control a. Personal Hygiene b. Aseptic Technique c. Communicable Disease d. Precautions e. Cleaning and Disinfecting, Equipment f. Storing and handling supplies		

	g. Standard Precautions h. Blood borne pathogens i. Vaccinations • TB Skin Test • Hepatitis B or waiver • Rubella • Tetanus • Influenza • Varicella j. Equipment Management • Electric and Manual Breast Pumps k. Identifying, handling, and disposing of hazardous materials l. Safety Data Sheets m. Personal Protective Equipment • Gloves • Impermeable Gown • Vent Mask • Antibacterial hand wash • Spill kit • N-95-Respirator mask • Goggles/Face shield		
	4. Screening and reporting for child and adult abuse and neglect		
	5. Community Resources and Collaboration		
	6. Continuing Education Requirements		
	7. Employee Performance Evaluation		
C.	Quality Improvement 1. Quality Improvement Council and purpose 2. Call supervisor by 7:00 am if not reporting to work 3. Job description 4. Monitoring/Tracking Performances a. Client Satisfaction Surveys b. Program Audits c. Incident Reports d. Client Complaints		
D.	Preceptor Assigned and Receive WIC Training Checklist		
E.	Orientation period		
F.	Program Area 1. Introduction to worksite 2. Introduction to program 3. Schedule M-F 4. Scope of services and program policy review 5. Service/Program Record Documentation in Crossroads 6. Crossroads Training		

G.	Expectations of the WIC Management Support 1. Report to clinic as assigned in a timely manner 2. Accounts for all work hours through sign-out sheets leave records and time sheets 3. Reviews and updates job description annually 4. Adheres to dress code – displaying a professional appearance 5. Establishes an effective working relationship with Others 6. Review appropriate computer screens prior to client Contact 7. Introduce self to client and state purpose 8. Use appropriate communication skills 9. Review relevant parts of the WIC Program Manual 10. Reliable in following procedures/policies 11. Provides services to clients according to standards, program guidelines and collaborates with other disciplines 12. Treats public with courtesy and respect 13. Maintains complete confidentiality of client information		
F.	Accreditation process – development, implementation and maintenance		

Employee Signature: _____ Date_____

Supervisor Signature: _____ Date_____

- When completed the supervisor needs to submit a copy to the Personnel Assistant for filing in the training record.
- The Orientation checklist should be completed at the end of the employee's probationary status if at all possible.

Date Developed: 7/14
Reviewed: 6/15; 6/16; 6/17; 6/18; 6/19; 6/20; 6/21; 6/22; 6/23; 6/24
Revised: 6/17

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